# *WISCONSIN HOSPITAL EMERGENCY PREPAREDNESS PLAN*

*Version No. 3*

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# Glossary & Acronyms

| Term | Definition |
|---|---|
| **2-1-1- Wisconsin** | A statewide telephone communications networks for disseminating public health information. |
| **ACIP** | **Advisory Committee on Immunization Practices** (for CDC) |
| **AII** | **Airborne Infection Isolation** |
| **AII Room** | An inpatient room in any functional area of the hospital that is engineered to provide a negative pressure atmosphere in that room. |
| **All-Hazard** | Covering all possible hazards whether natural, accidental, negligent, or intentional |
| **Anthrax** | A non-contagious potentially fatal disease caused by breathing, eating, or skin contact with spores of the skin bacteria known as Bacillus anthracic. |
| **APIC** | **Association of Professionals in Infection Control and Epidemiology** |
| **Appendix** | For the purpose of this plan an appendix is a reference to a related or supporting plan maintained by another organization. |
| **Attachment** | For the purpose of this plan an attachment is a document, table, diagram or chart that supports the plan section where it is identified. |
| **Biological Agent** | Living organisms, the materials derived from them that cause disease in, or harm humans, animals, plants, or cause deterioration of material. Biological agents that may be found a liquid droplets, aerosols, or dry powders. A biological agent can be adapted and used as a terrorist weapon, such as anthrax, tularemia, cholera, encephalitis, plague, or botulism. There are three different types of biological agents: bacteria, viruses, and toxins. |
| **Biological Attack** | The deliberate release of bacteria, viruses, or toxins to produce death or disease in humans, animals, or plants. |
| **Biological Incident** | A natural, accidental, negligent, or deliberate exposure involving a biological agent. |

## Glossary & Acronyms

| Term | Definition |
|---|---|
| **Bio-Safety Level** | A system for classifying laboratory safety practices, in four levels according to degree of protection provided to personnel, the environment, and the community for laboratories dealing with infectious microorganisms.<br>• BSL1 – suitable for work involving well characterized agents not known to consistently cause disease in health adult humans, and of minimal potential hazard to laboratory personnel and the environment.<br>• BSL 2 – similar to BSL 1 and is suitable for work involving agents of moderate potential hazard to personnel and the environment<br>• BSL 3 – applicable to clinical, diagnostic, teaching, research, or production facilities in which work is done with indigenous or exotic agents which may cause serious or potentially lethal disease as a result of exposure by the inhalation route.<br>• BSL 4 – required for work with dangerous and exotic agents that pose a high individual risk of aerosol-transmitted laboratory infections and life-threatening disease. |
| **Bioterrorism** | The use of a biological agent in a terrorist incident, the intentional use of microorganism or toxin to produce death or disease in humans, animals, or plants. |
| **BOIDOOPHTE** | **Bioterrorism, Other Infectious Disease Outbreaks and Other Public Health Threat Emergencies** |
| **BQA** | **Bureau of Quality Assurance** |
| **Category-A Agents** | The biological terrorism agents having the greatest potential for adverse public health impact with mass casualties. |
| **Category-A Diseases** | The Category-**A** diseases are smallpox; anthrax; plague; botulism; tularemia; viral hemorrhagic fevers (e.g. Ebola and Lassa viruses). |
| **Category-B Agents** | Agents are more readily available, may not necessarily cause mass casualties, and their use may often be found more often in the settings of biological crime or extortion than terrorism. |
| **Category-C Agents** | Emerging infectious diseases or agents with characteristics that could be exploited for deliberate dissemination. |
| **CDC** | **Centers for Disease Control and Prevention** (agency of HHS) |
| **CERT** | **Community Emergency Response Team** |
| **Characterization** | Identification of the strain of an influenza virus such as A/Panama. |
| **Chemical Warfare Agent** | A chemical substance (such as a nerve agent, blister agent, blood agent, choking agent, or irritating agent) used to kill, seriously injure, or incapacitate people through its physiological effects. |

## Glossary & Acronyms

| Term | Definition |
|---|---|
| **Clinical Labs** | Reference Laboratories, previously referred to as "Level B" and "Level C" laboratories; provide confirmatory testing for the agents of bioterrorism. Reference Laboratories are usually public health laboratories that have BSL-3 capabilities, can confirm the identification of bioterrorism agents using conventional and molecular methods, and have rapid methods capability.<br>The Wisconsin State Laboratory of Hygiene (WSLH) serves as the coordinating laboratory of the Wisconsin Laboratory Response Network (WLRN). The Milwaukee Health Department Bureau of Laboratories and Marshfield Clinical Research Foundation Laboratory also serve as Reference Laboratories for bioterrorism. The WSLH serves, as Wisconsin's only Reference Laboratory for chemical terrorism response. |
| **CMEO** | **Coroner/Medical Examiner** |
| **CMFMP** | **County Mass Fatality Mortuary Plan** |
| **COBRA** | **Consolidated Omnibus Budget Reconciliation Act** |
| **Cohorts** | A group of people united in an effort or difficulty. |
| **Communicable Disease** | An illness due to a specific infectious agent or to toxic products that arises through transmission of that agent or its products from an infected person or animal to a susceptible host. |
| **Communications** | The system by which the message is communicated. |
| **Crisis Communication** | Exchange of information concerning the existence, nature, form, severity, or acceptability of health or environmental risks. |
| **DATCP** | **Department of Agriculture Trade and Consumer Protection** |
| **DCFS** | **Division of Children and Family Services** |
| **Decontamination** | The process of making people, objects, or areas safe by absorbing, destroying, neutralizing, making harmless, or removing chemical, biological, or radiological material |
| **DHFS** | **Department of Health and Family Services** |
| **Disaster, major (federal)** | "Major disaster" means any natural catastrophe (including any hurricane, tornado, storm, high water, wind driven water, tidal wave, tsunami, earthquake, volcanic eruption, landslide, mudslide, snowstorm, or drought) or regardless of cause, any fire, flood, or explosion, in any part of the United States, which in the determination of the President, causes damage of sufficient severity and magnitude to warrant major disaster assistance under the Stafford Act. |
| **DMAT** | **Disaster Medical Assistance Team** |

## Glossary & Acronyms

| Term | Definition |
|---|---|
| **DMORT** | A coordinated effort of forensic experts and mortuary personnel to effectively handle a mass fatality disaster |
| **DOA** | **Department of Administration** |
| **DPH** | **Department of Health** |
| **DPI** | **Department of Public Instruction** |
| **Drills** | Small-scale, internally conducted, activities aimed at providing a more "hands-on" teaching environment to familiarize staff with the actual procedures necessary for emergency operations. |
| **Emergency** | A natural or manmade event that suddenly disrupts the environment of care; disrupts care and treatment; or changes or increases demands for the organization's resources. |
| **EMS** | **Emergency Medical Service** - Private or community operated companies or squads that provide prompt response medical assistance at the location of the emergency. Also looked to for transport of victims to a fixed medical facility. |
| **EMT** | **Emergency Medical Technician** - A practitioner credentialed by a State to function as an EMT by a State Emergency Medical (EMS) system. |
| **Endemic** | A disease that is continually present in a community or a region. |
| **EOC** | **Emergency Operating Center** - A facility in the local community that is use to gather, coordinate, communicate and make decisions for the health and well being of the community they serve during times of natural or man-made disaster. |
| **EOP** | **Emergency Operations Plan** |
| **EPA** | **Environmental Protection Agency** (US) |
| **Epidemic** | The occurrence of a disease in a community or region clearly in excess of normal expectations. |
| **Event** | An occurrence involving biological or infectious disease agents that is caused by a criminal act or natural occurrence requiring a response greater than that seen during a normal day's activity. |
| **Exercise** | Large-scale enactment of emergency situations to test the response s |
| **FDA** | **Food and Drug Administration** (agency of HHS) |
| **Febrile** | Denoting or relating to fever. |
| **FIRST** | **Fatality Incident Response Support Team** (formerly – Disaster Assistance Response Teams) |

## Glossary & Acronyms

| Term | Definition |
|---|---|
| **First Responder** | Those individuals who in the early stages of an incident are responsible for the protection and preservation of life, property, evidence, and the environment |
| **HAN** | **Health Alert Network** - An Internet based program used to communicate health and emergency messages |
| **Hazard** | A source of potential harm from past, current, or future exposures |
| **Hazards Vulnerability Analysis** | |
| **HazMat** | **Hazardous Materials** - Any material that is explosive, flammable, poisonous, corrosive, reactive, or radioactive, or any combinations thereof, and require special care in handling because of the hazard it poses to public health, safety, or the environment. |
| **HEICS** | **Hospital Emergency Incident Command System –** An emergency management system that employ a logical management structure, defined responsibilities, clear reporting channels, and common nomenclature to help unify hospitals with other emergency responders. |
| **HEPP** | **The State of Wisconsin Hospital Emergency Preparedness Plan** |
| **HHS** | **Department of Health and Human Services** (US) |
| **High-Hazard Area** | Geographic location that for planning purposes has been determined through historical experience and vulnerability analysis to be likely to experience the effects of a specific hazard (e.g. hurricane, earthquake, hazardous materials accident, etc.) resulting in vast property damage or loss of life. |
| **HIPAA** | **Health Insurance Portability and Accountability Act** |
| **HRSA** | **Health Resources and Services Administration** - This agency of the U.S. Department of Health and Human Services, HRSA assures the availability of quality health care to low income, uninsured, isolated, vulnerable and special needs populations and meets their unique health care needs. |
| **ICP** | **Infection Control Professional** |
| **ICS** | **Incident Command System** – The direction and control scheme used by first response and other agencies to manage emergencies |
| **ILI** | **Influenza-like Illness** – The presence of fever >100d. F, with a cough or sore throat. |
| **Incident** | A slow or fast developing mass casualty situation, which may be caused by any of a number of initiators such as an act or bioterrorism, a naturally occurring infectious disease outbreak or any circumstance that could produce a large number of casualties. |

## Glossary & Acronyms

| Term | Definition |
|---|---|
| **JIC** | **Joint Information Center** - A pre-determined location at which the public information officers from the organizations represented in a activated Emergency Operations Center can gather to develop and verify information that need to be transmitted to the public using both broadcast and print media. |
| **JPIC** | **Joint Public Information Center** - A central location for involved agencies to coordinate public information activities and a forum for news media representatives to receive disaster or emergency information |
| **Laboratory Levels** | A system for classifying CDC, Department of Defense, FBI, and US Army Medical Research Institute of Infectious Diseases laboratories by their capabilities. Classification levels are:<br>• A – routine clinical testing, Includes independent clinical labs and those at universities and community hospitals.<br>• B – More specialized capabilities. Includes many state and local public health laboratories.<br>• C – More sophisticated public health labs and reference labs such as those run by CDC.<br>• D – Possessing sophisticated containment equipment and expertise to deal with the most dangerous, virulent pathogens. |
| **LIN** | **Laboratory Information Network** |
| **LPHD** | **Local Public Health Department** |
| **MHDOHL** | **Milwaukee Health Department Public Health Laboratory** |
| **MMRS** | **Metropolitan Medical Response System** – A program intended to increase cities' ability to respond to a terrorist attack by coordinating the efforts of local law enforcement, fire, HazMat, EMS, hospital, public health, and other personnel. |
| **N95** | Filtering characteristic of an effective mask, resistant to aerosol hazards. |
| **NEDSS** | **National Electronic Disease Surveillance System** – a CDC initiative promoting the use of data and information system standards to improve disease surveillance systems at federal, state, and local levels. |
| **NIMS** | **National Incident Management System** – the single all-hazard incident management system required by Department of Homeland Security (DHS) Presidential Directive 5 that will govern the management of the National Response Plan. NIMS will replace the National Inter-Agency Incident Management System. |
| **Novel virus** | A virus rarely or not previously known to infect humans. |

## Glossary & Acronyms

| Term | Definition |
|---|---|
| **NPAir** | **Negative Pressure Air Room** - An inpatient room in any functional area of the hospital that is engineered to provide a negative pressure atmosphere in relation to the corridor and surrounding areas with exhaust externally vented away from air intakes or where people may pass. |
| **NREVSS** | **National Respiratory and Enteric Virus Surveillance System** |
| **Outbreak** | The occurrence of a number of cases of a disease or condition in any area over a given period of time in excess of the expected number of cases. |
| **Pandemic** | The occurrence of a disease in excess of normal expectations in extensive regions, countries, or continents. |
| **PIO** | **Public Information Officer** |
| **PPE** | **Personal Protective Equipment** – Equipment and clothing required to shield or isolate personnel from the chemical, physical, thermal, or biological hazards that may be encountered at a hazardous materials incident. |
| **Preparedness** | Refers to the existence of plans, procedures, policies, training, and equipment necessary at the federal, state, and local levels to maximize the ability to prevent, respond to, and recover from major events. “Readiness” is used interchangeably with “Preparedness” |
| **Public Health** | Organized efforts of society to protect, promote, and restore peoples’ health. It is the combination of science, skill, and beliefs that is directed to the maintenance and improvement of the health of all the people through collective or social actions. |
| **Public Health Emergency** | Occurrence or imminent threat of exposure to an extremely dangerous condition or a highly infectious or toxic agent, including a communicable disease, that poses an imminent threat of substantial harm to the population, or any portion thereof. In general, a public health emergency is one that requires a population-based approach. |
| **Push Package** | A large shipment of medical supplies and pharmaceuticals sent from the Strategic National Stockpile to a state undergoing an emergency within 12 hours of federal approval of a request by the states’ Governor. |
| **Quarantine** | Precautionary physical separation of persons who have or may have been exposed to a threatening communicable disease or a potentially threatening communicable disease and who do not show signs or symptoms of a threatening communicable disease from non-quarantined persons. |
| **Radiation** | High-energy particle or gamma ray that is emitted by an atom as the substance undergoes radioactive decay. These can be either charged alpha or beta particles or neutral neutron or gamma rays. |
| **Radiological Material** | Any material that spontaneously emits ionizing radiation. |

## Glossary & Acronyms

| Term | Definition |
|---|---|
| **Release** | Any spilling, leaking, pumping, pouring, emitting, emptying, discharging, injecting, escaping, leaching, dumping, or disposing into the environment (including the abandonment or discharging of barrels, containers, or other closed receptacles containing any hazardous substance, pollutant, or contaminant). |
| **Response** | Activities to address the immediate and short-term effects of an emergency or disaster. Response includes immediate actions to save lives, protect property, and meet basic human needs as well as executing the plan and resources created to preserve life, protect property, or provide services. |
| **Risk** | A measure of the harm to human health that results from exposure; uncertainty that surrounds future events and their outcome. |
| **SARS** | **Severe Acute Respiratory Syndrome** |
| **Sentinel Labs** | Sentinel Laboratories, previously referred to as "Level A" laboratories, are clinical laboratories that perform microbiology and operate at BioSafety Level 2 (BSL-2), but would adopt BioSafety Level 3 (BSL-3) practices when working with a suspected bioterrorism agent. Any clinical laboratories that perform bacteriology and are CLIA certified may be Sentinel Laboratories, with no formal registration required.<br>The role of Sentinel Laboratories is to recognize the agents of bioterrorism, perform testing to rule out the agents of bioterrorism, and refer suspect isolates to Reference Laboratories.<br>In Wisconsin, Sentinel Laboratories are comprised of hospital-based and large clinical laboratories that perform microbiology; the use of a Biological Safety Cabinet (BSC) and biosafety level 2 criteria have not been strictly applied for inclusion in the Wisconsin Laboratory Response Network. |
| **Smallpox** | Variola, a virus that causes a serious, contagious, and sometimes fatal disease, producing substantial morbidity and mortality. There is no specific treatment for smallpox and the only prevention is vaccination. |
| **SNS** | **Strategic National Stockpile** - A federal cache of medical supplies and equipment to be used in emergency and disaster situations |
| **Special Populations** | People who might be more sensitive or susceptible to exposure to hazardous substances because of factors such as age, occupation, sex, or behavior (for example, cigarette smoking); those with special needs for translations, special services or alternative channels of communication (such as the deaf); populations with distinct cultural or community needs. Children, pregnant women and older people are often considered special populations. |
| **Stakeholder** | And individual, group, or organization that may be affected by or otherwise interested in a risk management decision. |
| **Subtype** | Identification of influenza A viruses according to the hemagglutinin (H) and neuraminidase (N) components of the virus, such as H1N1 or H3N2. |

## Glossary & Acronyms

| Term | Definition |
|---|---|
| **Surge Capacity** | The accommodation by the health system to a transient sudden rise in demand for health care following an incident with real or perceived adverse health effects. |
| **Surveillance** | The collection, analysis and dissemination of data |
| **Sustainability** | Ability to continue response operations for the prescribed duration necessary. |
| **Syndromic** | Based on clinical signs and symptoms |
| **Terrorism** | The unlawful use of force or violence against persons or property to intimidate or coerce a government, the civilian population, or any segment thereof, in furtherance of political or social objectives. |
| **Threatening Communicable Disease** | The term used in relation to the reporting of communicable diseases in the Public Health Act and defined in the Public Health Emergency Response Act. This term means a disease that causes death or threat that passes from on person to another and for which there is no means by which the public can reasonably avoid the risk of contracting the disease. The term does not include infection with the human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS), or other infections attributable to infection with HIV. |
| **Triage Tag** | A multi purpose tag that is used by emergency medical or field medical personnel when documenting the medical condition and treatment category of event victims in the field. |
| **Vaccination** | The injection or inoculation of a vaccine for the purpose of inducing active immunity |
| **VAERS** | **Vaccine Adverse Events Reporting System** |
| **Virus** | The simplest types of microorganisms, lacking a system for their own metabolism. They depend on living cells to multiply and cannot live outside of a host. Types of viruses include smallpox, Ebola, Marburg, and Lassa fever. |
| **VIS** | **Vaccine Information System** |
| **WMD** | **Weapons of Mass Destruction** :<br>• Any “destructive device” defined as any explosive, incendiary, or poison gas, bomb, grenade, or rocket having a propellant charge of more than 4 ounces, missile having an explosive or incendiary charge of more than ¼ ounce.<br>• Any device, material, or substance used with intent to cause death or serious injury to persons or significant damage to property. |
| **WEAVR** | **Wisconsin Emergency Assistance Volunteer Registry** |
| **WEM** | **Wisconsin Emergency Management** |
| **WHO** | **World Health Organization** |

## Glossary & Acronyms

| Term | Definition |
|---|---|
| **WIR** | **Wisconsin Immunization Registry** |
| **WMD Chem/Bio** | Shorthand phrase for "Weapons of Mass Destruction, Chemical/Biological," in reference to those substances that were developed by military institutions to create widespread injury, illness, or death. |
| **WSLH** | **Wisconsin State Laboratory of Hygiene** |
| **Zone, Contamination Reduction (Warm Zone)** | The area between the Exclusion Zone and the Support Zone. This zone contains the personnel decontamination station. This zone may require a lesser degree of personnel protect than in the Exclusion Zone. This separates the contaminated area from the clean area and acts as a buffer to reduce contamination of the "clean" area. |
| **Zone, Exclusion (Hot Zone)** | The area immediately around a spill or release and where contamination does or could occur. Special protection is required for all personnel while in this zone. |
| **Zone, Support (Cold Zone)** | The "clean" area outside of the contamination control line. In this area, equipment and personnel are not expected to become contaminated. Special protective clothing is not required. This is the area where resources are assembled to support the hazardous substances/materials release operation |

## L-1: Surveillance Reporting and Health Insurance Portability & Accountability Act (HIPAA)

HIPAA does not change the obligations of health care providers to report communicable diseases and other events of public health interest to local or state health departments.

The privacy rules expressly permit disclosures of Protected Health Information (PHI), without prior consent of patients, to public health agencies so that public health activities such as disease control and prevention can continue. Hence, the rules permit covered entities to continue the same reporting relationships with their public health partners. It does so by the following provisions:

- Disclosures of PHI to public health agencies do not require prior consent. Health care providers can report individually identifiable health data to local and state health departments without obtaining consent from their patients.

- Federal privacy rules uphold state statutes that require disease and injury reporting to public health authorities. The requirements of Chapter 252 of the Wisconsin State Statutes are not affected by the Federal privacy rules.

- All those responsible for reporting to local and state health departments (e.g. health care providers, laboratory staff, and infection control professionals) should be advised that they can and must continue to report necessary patient information to public health authorities. The Division of Public Health and local health departments will in turn maintain the privacy of all patient information.

## Ad 1: Introduction

**A.** The Plan Purpose and Scope

**1.** The purpose of the Wisconsin Hospital Emergency Plan (WHEPP) is to establish the structure and process necessary to enable the participating institutions in the State of Wisconsin to meet community, county and regional needs in a collaborative and organized manner during an incident. An "incident" is defined as a slow or fast developing mass casualty situation, which may be caused by any of a number of initiators such as, an act of bioterrorism, a naturally occurring infectious disease outbreak or any circumstance that could produce a large number of casualties. An "emergency" is defined as a natural or manmade incident that suddenly disrupts the environment of care; disrupts care and treatment; or changes or increases demands for the organization's resources.

**2.** The scope of the WHEPP is to describe the process for: sharing resources between participant institutions; activating the WHEPP; operational parameters during the incident between participant institutions and field operations; termination of the incident; recovery; and the process for evaluating performance under the WHEPP. This scope may be realized if the following planning objectives are developed:

**a.** A method that enables the participant institutions to meet community healthcare needs during an incident, in which an individual institution's capacity is exceeded.

**b.** A method for the participant institutions that is consistent and integrates with the community emergency response plans developed by civil authorities with an emphasis on integrating pre-hospital, hospital and home care.

**c.** A method that provides for pre-determined initiating "triggers," pre-hospital communication, resource mobilization and transportation to the appropriate hospital(s) and/or off-site treatment facilities. An incident may quickly overwhelm the resources (physical plant and staff) of participant institutions. When such an incident occurs, mutual aid with other participant institutions and/or community, regional, state or national resources is required.

**d.** A method to evacuate partially or fully any participant institution, should it be necessary as a result of either an internal or external disaster, affecting a participant institution (See Part F of this plan).

**e.** A method for determining when the response to an incident may be terminated and hospital activities return to normal routines.

**B.** Administrative Oversight and Authority

**1.** In recognition of the growing public concern with bioterrorism issues, the Division of Public Health formed its own WDPH Interagency Working Group to specifically focus state attention and expertise on issues of bioterrorism. Following the direction provided in the "Bioterrorism Hospital Preparedness Program Cooperative Agreement Guidance" developed by the Health Resources and Services Administration of the U.S. Department of Health and Human Services (February 15, 2002), the State of Wisconsin applied for and received the grant needed to develop a state wide bioterrorism preparedness plan based on regional response capabilities within the State. After receipt of this grant the Working Group expanded into the Wisconsin Coordinating

## Ad 1: Introduction

Committee on Bioterrorism Preparedness charged with bringing input from a wider body of participants into implementation of the grant.

**2.** The goal of this committee was to provide a plan without borders, that would serve the people in the State of Wisconsin as well as accepting and providing assistance to neighboring states in the event of a bioterrorism incident of mass casualty proportion.

**3.** With recognition that a mass casualty incident due to a biological, chemical, radiological or natural disaster can easily overwhelm or damage the capability of local healthcare resources to meet community needs, this Wisconsin Hospital Emergency Preparedness Plan (WHEPP), a mutual aid plan, is developed.

**4.** To this end and with the understanding that participation in this program by Wisconsin hospitals is not mandatory, an expectation exists that all hospitals participating in this program have an obligation to support and implement the program as defined in the WHEPP.

**5.** To implement the WHEPP, participant institutions are expected to comply with applicable Federal and State laws unless otherwise suspended per statute.

**6.** To foster unity, a state Leadership Committee and Boards are to be established in keeping with the guidance in Attachment 1, Membership (See Part D of this plan).

## Ad 1: Introduction

**C.** Historical Background

**1.** The Wisconsin Division of Public Health (WDPH), and the State's public health system has experience with major communicable disease outbreaks and other public health emergencies, that far predate the incidents surrounding the terrorist attack on the United States on September 11, 2001. Probably the best known of these are the massive Cryptosporidium outbreak which occurred in the city of Milwaukee in 1993, and the chemical car train derailment which occurred in the village of Weyauwega in central Wisconsin in 1996.

**2.** These incidents involved the mobilization of large numbers of state and local public health agency and laboratory staff for extended periods of time, as well as significant private sector involvement in a coordinated effort.

**3.** There is likely to be two categories under which an incident may be initiated. They are:

**a.** Fast Breaking Incident - This incident develops rapidly and produces a large number of casualties in a very short period of time.

**b.** Slow Developing Incident - This incident develops gradually over time, involves a biological or infectious agent, and produces a large number of casualties over a sustained period of time.

**4.** Severity levels, which are consistent with federal guidelines, for an incident are as follows:

**a.** Level 1 – the participant institution(s) in the affected community can care for all the patients.

**b.** Level 2 – the participant institution(s) in the affected community require the resources of other participant institutions and off-site treatment facilities in the region.

**c.** Level 3 – the participant institution(s) in the community require the support of other participant institutions and off-site treatment facilities in one or more neighboring regions or those of a neighboring state.

**d.** Level 4 – the incident is national in scope in that a Level 3 incident exists in two or more states

**D.** Relationship to State and County Emergency Plans

The concept of operation of the WHEPP is to be developed as a collaborative plan to the State of Wisconsin, Public Health Emergency Plan (PHEP). Additionally the WHEPP is to be developed as supporting plan to the State of Wisconsin Emergency Operations Plan, Annex H, "Health and Medical" (See Part E of this plan) and the Annex H, "Health and Medical" (See Part E of this plan) of the respective County Emergency Operations Plans.

## Ad 1: Introduction

**Related Documents**:

**A.** Legal:
- **1.** None

**B.** Part C: Resource Lists
- **1.** None

**C.** Part D: Attachments
- **1.** Att-Ad-1A, Membership

**D.** Part E: Appendices
- **1.** None

**E.** Part F: Checklists
- **1.** Ck-Ad-1A, Hospital Preparedness
- **2.** Ck-Ad-1B, Purpose and Objectives
- **3.** Ck-Ad-1C, Membership
- **4.** Ck-Ad-1D, Scope of Plan

## Ad 2: Post Incident Evaluation

**Purpose**:

The purpose of this section is to provide guidance for generating an incident evaluation report following an incident in a community.

**Scope**:

The scope of this section will cover the responsibilities of the Emergency Operating Center (EOC) and/or the Base Hospital (BH). It will define the process to be used, expected completion time frame, evaluation focal points and the distribution of the finished report.

**Concept of Operation**:

**A.** The EOC and/or BH from the regions involved in the incident are to organize a meeting for the purpose of conducting an evaluation of the incident against the guidelines of the WHEPP.

**B.** The evaluation is to be initiated as soon as possible after the incident and completed within 90 days. Representatives from each participating hospital are expected to support the evaluation by providing originals or copies of all logs and documents generated at their respective organization during the incident.

**C.** The evaluation is to provide the following deliverables:

**1.** A listing of all participant hospitals and supporting organizations to the participant hospitals.

## Ad 2: Post Incident Evaluation

NOTE: A comprehensive time-line of actions taken and significant notifications (send and received) by all participating hospitals can be very helpful in identifying areas for improvement as well as program strengths.

**2.** Evaluate the incident against the guidelines provided in the following sections of the WHEPP:

NOTE: If one or a number of these sections was not implemented during the incident a statement to that fact is to be entered into the incident evaluation report.

**a.** Part A, Administrative sections Ad-1 through Ad-3
**b.** Part B, Operation sections Op-1 through Op-18

**3.** For each section of the WHEPP identify the following:

**a.** The strengths and aspects of the response that met or exceeded the expectations of the WHEPP.

**b.** The areas needing improvement and aspects of the response that did not meet the expectations of the WHEPP.

**4.** Identify recommendations to address or resolve the areas needing improvement.

## Ad 2: Post Incident Evaluation

### Related Documents

**A.** Legal:
- **1.** None

**B.** Part C: Resource Lists
- **1.** None

**C.** Part D: Attachments
- **1.** None

**D.** Part E: Appendices
- **1.** None

**E.** Part F: Checklists
- **1.** Ck-Ad-2, Post Incident Evaluation

# Ad 3: Plan Approval

**Purpose**:

The purpose of this section is to define the expectations for reviewing and approval of the Wisconsin Hospital Emergency Preparedness Plan (WHEPP).

**Scope**:

The scope of this section will address how often the WHEPP is to be reviewed, how revisions will be approved and how the revision is to be implemented and distribution guidance.

**Concept of Operation**:

**A.** The WHEPP is to be reviewed at least once every two years. However, the WHEPP may be reviewed at any time or as a result of an incident or exercise evaluation.

**B.** A writer's guide has been provided as an attachment to this section to provide for consistent formatting and plan continuity (See Part D, Attachments below).

**C.** The WHEPP revision recommendations may come from, but not limited to:

**1.** HRSA Regional Boards

**2.** Incident or Exercise Evaluation Committees

**3.** Individual participant hospitals or agencies that have a direct working relationship with the WHEPP or who have new information that would be the basis for a legitimate change to the WHEPP.

## Ad 3: Plan Approval

**D.** The HRSA Leadership Committee or a sub-committee designated by the Leadership Committee is to evaluate and approve recommended changes to the WHEPP.

**E.** Based on the nature of the revisions identified, these revisions are to be implemented immediately or deferred to the next designated review period.

**F.** Participant hospitals and supporting institutions are to be made aware of approved changes and how they can obtain a copy.

**Related Documents**:

**A.** Legal:
- **1.** None

**B.** Part C: Resource Lists
- **1.** None

**C.** Part D: Attachments
- **1.** Att-Ad-3A, Writer's Guide

**D.** Part E: Appendices
- **1.** None

**E.** Part F: Checklists
- **1.** Ck-Ad-3, Plan Approval

# Op 1: Surveillance

**Purpose**:

The purpose of this section is to provide guidance on surveillance issues relating to the early detection of biological agents and other infectious diseases that might result in a mass casualty event. **Note:** A future goal of this section is to provide guidelines on chemical agents and radioactive materials.

**Scope**:

The scope of this section will cover passive and enhanced surveillance expectations; statute mandated reporting that apply; and surveillance of health care givers. **Note:** Comments relating to Health Insurance Portability & Accountability Act (HIPAA) during a mass casualty incident may be found the Legal section of this plan L-1, Surveillance Reporting and Health Insurance Portability & Accountability Act (HIPAA):

**Concept of Operation**:

**A.** If the reporting protocols described here are performed on a regular basis by participant hospitals, laboratories, physician offices, and clinics early recognition of infectious diseases can be realized. As a result, prompt and effective treatment for individual's who are victims of an act of bioterrorism or other infectious disease mass casualty can be given.

**B.** For the purpose of this Plan "Passive Surveillance" is defined as the evaluation of available data on reportable diseases provided through mandatory or requested reporting. Typically the responsibility for reporting falls on health care providers or local health departments.

## Op 1: Surveillance

**C.** Wisconsin Statutes mandate the reporting of suspected or confirmed cases of Category I, II, and III communicable diseases.

**1.** Two appendices to this Section are provided:

**a.** Appendix 21-A, "Category I, II and III Reportable Diseases" provides a list of all diseases identified for these three categories.

**b.** Appendix 21-B, "CDC Category A, B and C Diseases" provides a listing of the diseases under these three categories and general information about each category.

**2.** The reporting of these cases will trigger one or more of the following activities by local Health Departments and/or the Wisconsin Division of Public Health for input to the Centers for Disease Control and Injury Prevention:

**a.** A high–risk assessment by the local health department to determine if the patient or a member of the patient's household is employed in food handling, day care, or health care.

**b.** A source investigation by the local health department to track down the origin of the disease.

**D.** Chapter HFS 145, "Control of Communicable Diseases," Appendix A, "Communicable Diseases" provides the reporting expectations for the three categories of communicable diseases. These expectations are summarized below:

**1.** CATEGORY I

**a.** Are diseases of urgent public health importance and are to be reported **IMMEDIATELY** to the local health department upon identification of a case or suspected case.

**b.** Complete and mail an Acute and Communicable Diseases Case Report (DOH 4151) within 24 hours.

**2.** CATEGORY II

**a.** Diseases are to be reported to the local health officer, on an Acute and Communicable Diseases Case Report (DOH 4151) or by other means.

**b.** This is to be accomplished within 72 hours of the identification of a case or suspected case.

**3.** CATEGORY III

**a.** Diseases are to be reported to the state epidemiologist.

**b.** This is to be accomplished within 72 hours after identification of a case or suspected case.

## Op 1: Surveillance

**E.** For the purposes of this plan, "Enhanced Surveillance" is defined as a situation in which there is a suspicion that a particular disease or agent is present in a community.

**1.** In this situation hospitals and physicians and other clinicians will be alerted through the Wisconsin Health Alert Network (HAN). This enhanced surveillance alert will include:

**a.** The specific disease or agent for which to initiate surveillance.

**b.** The prodrome and syndrome of this particular disease or agent.

**c.** The treatment protocols for this particular disease or agent.

**d.** The methods for rapid reporting of the detection of this particular disease or agent.

**e.** The risk communications for patients and the general public regarding this particular disease or agent.

**F.** Surveillance and Reporting of the Number of Sick Employees

**1.** Participating hospitals are to implement a method for reporting the following to their local health department:

**a.** An unusual number of employees who call in sick.

**b.** The reason for the sickness, if available.

**2.** To accomplish this the following method elements are to be considered:

**a.** Establish an office within the participant hospital for reporting employees who have called in sick. (e.g. Human Resources, Occupational Health, Employee Health, etc.).

**b.** Each department director, manager, or supervisor is to determine a threshold number that triggers a call to report sick employee information to the office identified above.

**c.** The participant hospital is to determine a threshold number at which the hospital will call their local Health Department to report employee sickness information.

**Related Documents**:

**A.** Legal:
- **1.** L-1, Surveillance Reporting and Health Insurance Portability & Accountability Act (HIPAA):

**B.** Part C: Resource Lists
- **1.** None

**C.** Part D: Attachments
- **1.** Att-Op-1A, Category I, II and III Reportable Diseases
- **2.** Att-Op-1B, CDC Category A, B and C Diseases

**D.** Part E: Appendices
- **1.** None

**E.** Part F: Checklists
- **1.** Ck-Op-1, Surveillance

# Op 2: Identification of an Unusual Infectious Disease or Incident of Bioterrorism

**Purpose:**

The purpose of this section is to define the protocols that a physician, clinician or a hospital staff member is to initiate when there is a suspected or confirmed case(s) of infectious disease that indicates an unusual outbreak of that disease or a potential incident of bioterrorism.

**Scope**:

The scope of this section will provide a qualitative and quantitative definition for "unusual" outbreak and identify three threshold levels of clinical decision making.

**Concept of Operations**:

**A.** Definitions of "Unusual" Outbreak

**1.** Qualitatively, unusual should have a low threshold. It is better to err than to delay reporting.

**2.** Quantitatively, (See Appendix 4.5)

**B.** Clinical Decision Threshold One:

**1.** A physician, clinician, or hospital staff member that perceives that an infectious disease in one or more patients may indicate an unusual outbreak of infectious disease or bioterrorism incident, is to **immediately notify Infection Control** for their facility.

**Op 2: Identification of an Unusual Infectious Disease or Incident of Bioterrorism**

**2.** Isolation protocols are to be immediately implemented for the affected patient(s).

**3.** Standard precautions are to be followed at all times.

**4.** Confer with colleagues regarding the case(s) of infectious disease that are presenting.

**5.** Infection Control is to **immediately** notify the Local Health Department (LHD).

**6.** IF, the LHD concurs that there is suspicion of an unusual outbreak of infectious disease or an incident of bioterrorism, the LHD is expected to notify the Wisconsin Division of Public Health (DPH) and the Federal Bureau of Investigation (FBI).

**7.** IF, a border state may be affected, the adjacent LHD are to be contacted. They are expected to implement their established protocols and notify their state health department.

**8.** IF, after consultation between the DPH, the LDH, and the affected hospital(s), the consensus is that there is **not** an unusual outbreak of infectious disease or incident of bioterrorism, then all these entities will continue to monitor and evaluate unusual presentations of infectious diseases.

**9.** IF, there is consensus among the hospital, the LHD, and the DPH that there is the potential for a bioterrorist incident or an unusual outbreak of infectious disease, then precede to Clinical Decision Threshold Two and Three**.**

**C. Clinical Decision Threshold Two**:

**1.** The hospital is to make a decision regarding the activation of its emergency management plan.

**2.** The LHD is expected to make a decision regarding the activation of its internal public health emergency plan.

**3.** The DPH is expected to:

**a.** Implement the Public Health Emergency Plan (PHEP).

**b.** Notify the Center for Disease Control (CDC) and adjacent state health department and consulted with them as appropriate.

**c.** Contact local health departments and clinicians and instruct them to implement enhanced surveillance. Use of the "Command Caller" feature of the Wisconsin Health Alert Network is recommended.

**Op 2: Identification of an Unusual Infectious Disease or Incident of Bioterrorism**

**D. Clinical Decision Threshold Three**:

**1.** The LHD(s) involved are expected to meet with the following agencies to evaluate the situation and decide whether it is necessary to activate the County/Tribal Emergency Operations Center (EOC):

- **a.** Emergency Management
- **b.** Law Enforcement
- **c.** Emergency Medical Services
- **d.** Others deemed necessary

**2.** IF there is consensus **not** to activate the County/Tribal EOC, then all organizations involved will continue to monitor and evaluate the infectious disease outbreak situation.

**3.** IF there **is** consensus to activate the County/Tribal EOC, the Wisconsin Hospital Emergency Preparedness Plan (WHEPP) is to be activated.

## Op 2: Identification of an Unusual Infectious Disease or Incident of Bioterrorism

**Related Documents**:

**A.** Legal:
- **1.** None

**B.** Part C: Resource Lists
- **1.** None

**C.** Part D: Attachments
- **1.** None

**D.** Part E: Appendices
- **1.** None

**E.** Part F: Checklists
- **1.** None

# Op 3: Notification of an Incident

**Purpose**:

The purpose of this section is to define the various aspects of notification and communication between participant organizations during a bioterrorism incident or infectious disease outbreak.

**Scope**:

This section will describe notification during a "fast breaking" and "slow developing" biological or infectious disease incident categories. Notification levels and triggers are identified. Guidance on which organizations are expected to notify other organizations will also be provided.

**Concept of Operation**:

**A.** Notifications during "Fast Breaking" Incidents

**1.** For this category of incident, notification to hospitals and other participant institutions should originate from a credible and recognized source.

**2.** Depending on the nature and scope of the incident, credible sources may include but are not limited to:

- **a.** a scene Incident Commander
- **b.** an Emergency Medical Services (EMS) unit
- **c.** a Fire Department
- **d.** a county or state Public Health Department
- **e.** a 911 Dispatch Center
- **f.** a law enforcement agency
- **g.** a county Emergency Management office
- **h.** another hospital

**3.** It is possible that patients may arrive at a hospital seeking treatment prior to any official notification.

**4.** The extent to which notification should be conducted is defined in the guidance provided below:

**a.** Incident Level I: A hospital should be notified by the responding EMS unit, 911 Dispatch Center or a scene Incident Commander. No further notification is necessary unless the incident expands to Level 2 or higher.

**b.** Incident Level 2, 3 or 4: Hospitals and other participant institutions should be notified by the responding EMS unit, 911 Dispatch Center. Hospitals, at this point, are expected to activate their internal and regional emergency plans.

**c.** Internal Hospital Damage: Hospitals, suffering internal damage, are to notify the 911 Dispatch Center that they are unable to accept patients. Either the hospital or 911 Dispatch Center is to provide this information to the County/Tribal Emergency Operating Center as soon as possible.

**B.** Notifications during a "Slow Developing" Incident

**1.** The precipitating act to a bioterrorism incident or infectious disease outbreak may be unknown until the appearance of syndromes or disease cases are recognized by Local Public Health Departments (LPHD) along with local

hospitals and clinics. Recognition and monitoring will be essential for prompt notification actions in this situation.

**2.** The extent to which notification should be conducted is defined in the guidance provided below:

**a.** Health care facilities that identify any unusual occurrence or pattern of disease symptoms of injury are to notify the LPHD immediately according to the protocols outlined in Section 21, "Surveillance" in the WHEPP.

**b.** The LPHD, in collaboration with the State Division of Public Health (DPH), is to confirm their findings with the initiating hospitals and clinics.

**c.** If the situation involves a suspected or confirmed case of unusual infectious disease, or exposure to a Center for Disease Control (CDC) Category A, B, C disease or an outbreak of infectious disease, the DPH and LPHD are to notify and communicate incident information to all appropriate health care facilities.

**d.** The DPH and LPHD are to consult with State and County/Tribal Emergency Management on the need to activate the state and County/Tribal Emergency Operating Centers (EOC) in accordance with established county emergency procedures.

**e.** If the decision is made to activate State and County/Tribal EOCs, supporting State and County/Tribal response agencies and hospitals are to be notified of this action by local Emergency Management.

## Op 3: Notification of an Incident

**Related Documents**:

**A.** Legal:
- **1.** None

**B.** Part C: Resource Lists
- **1.** None

**C.** Part D: Attachments
- **1.** Att-Op-3A, Incident Command System

**D.** Part E: Appendices
- **1.** None

**E.** Part F: Checklists
- **1.** Ck-Op-3, Notification of Incident

# Op 4: Infection Control Measures

## Purpose

The purpose of this section is to provide guidance on the means to provide an infection control plan for patients suspected or confirmed to have an airborne infectious disease, protective clothing needed while caring for these patients, and patient management.

## Scope

This section provides the recommendations for minimum negative pressure airborne isolation capacity, guidelines for negative pressure surge capacity, personal protective equipment needed for staff protection, and infection control practices for patient management.

## Concept of Operation

**A.** Each hospital is to have the following Airborne Infection Isolation (AII) rooms, which are built according to the requirements of the American Institute of Architects (AIA).

1. Two AII in the Emergency Department
2. One AII on the medical/surgical floor
3. One AII in the ICU, if the hospital has ICU services
4. Two percent of all staffed beds are to be AII
5. One AII with an anteroom per 100 staffed beds

**B.** Ten percent of staffed beds, above AII minimum recommendations, are to be Negative Pressure Surge Capacity (NPSC), if feasible. The definition of NPSC is:

**1.** A building, portion of a building, or individual rooms where patients suspected or confirmed to have an airborne transmitted infectious disease can be temporarily isolated during an emergency situation.

**2.** Because NPSC usually will have less than the required 12 Air Changes per Hour (ACH) the "trigger" to use these rooms is:

**a.** An outbreak of airborne transmitted disease

**b.** All available AII rooms are in use

**c.** The hospital informs the local health department that NPSC is being implemented and provides the Local Health Department (LHD) with the following information:

- The number of patients involved
- The signs and symptoms
- The origin of the patients
- Other pertinent information

**3.** The criteria for NPSC rooms or areas are:

**a.** Individual patient rooms must be negative in air pressure to the adjacent corridor.

**b.** Temporary areas must be negative in air pressure to all adjacent areas.

**c.** Each room or area must have a minimum of six ACH.

**d.** These air changes must be exhausted outside the building (preferred) or if this is not possible, the re-circulated air stream must be HEPA-filtered.

**4.** Investment in developing NPSC is not recommended if a hospital does not have (all) of the following clinical services.

**a.** ICU Services
**b.** 24/7 ventilator/respiratory support
**c.** 24/7 laboratory support
**d.** 24/7 respiratory care staff

**5.** With or without the minimum recommended AII or NPSC, each hospital is to have a plan to manage an increased number of patients with suspected or confirmed airborne transmitted infections and other communicable diseases. The plans are to include:

**a.** Protocols to transfer patients to another facility
**b.** Patient cohorting, once the disease is conformed
**c.** Opening rooms and/or areas that are NPSC or can provide isolation needs.

**C.** Personal Protective Equipment

**1.** The following items are to be included in the PPE inventory:

**a.** NIOSH-certified N95 or higher respirator in a variety of sizes
**b.** Appropriate medical gloves in a variety of sizes

**c.** Moisture resistant or higher level protection gowns in a variety of sizes

**d.** Shoe covers in a variety of sizes

**e.** Eye protection and/or face shields in a variety of sizes

**f.** Attachment Att-Op-4E, "Personal Protective Equipment Inventory Calculation Worksheet" provides a guideline for the amount of PPE that each hospital is to maintain in its inventory.

**g.** Hospitals are also to have Air Purifying Respirators (APR) for those situations and/or staff in which an N95 respirator and eye protection do not provide the necessary protection.

**2.** Re-Stocking Emergency Medical Services (EMS) personnel

**a.** Most Emergency Medical Services have PPE for their squad members to protection during a first response to a suspected infectious disease call.

**b.** If an incident is prolonged it will be necessary to provide clean PPE to them.

**c.** Therefore, participant hospitals or regions are to provide replacement PPE to EMS members if the need arises from either the regional interim inventory or the Strategic National Stockpile inventory.

**D.** Infection Control Practices for Patient Management:

**1.** Attachment Att-Op-4A, "Clinical Syndromes, Infectious Agents and Precautions" provides a table of clinical syndromes/conditions; select potential infectious agents, and precautions to us empirically.

**2.** Attachment Att-Op-4B, "Guidelines for Patient Management" provides a table of isolation precautions, patient placement, patient transport, cleaning, post-mortem care, discontinuation of isolation, and disposal of waste for a variety of bacterial agents, viruses and biological toxins

**3.** Attachment Att-Op-4C, "Infection Control & Isolation of a Suspected Case of Smallpox" and Attachment Att-Op-4D, "Infection Control for a Suspected Case of SARS" provide text material addressing evaluation and management of these two infectious diseases.

**4.** Attachment Att-Op-4F, "Procedure for Removing Personal Protective Equipment (PPE)" provides a method for the removal of PPE identified during patient management of the SARS outbreak in Toronto.

## Op 4: Infection Control Measures

**Related Documents**:

**A.** Legal:
- **1.** None

**B.** Part C: Resource Lists
- **1.** None

**C.** Part D: Attachments
- **1.** Att-Op-4A, Clinical Syndromes, Infectious Agents and Precautions
- **2.** Att-Op-4B, Guidelines for Patient Management
- **3.** Att-Op-4C, Infection Control & Isolation of a Suspected Case of Smallpox
- **4.** Att-Op-4D, Infection Control for a Suspected Case of SARS
- **5.** Att-Op-4E, Personal Protective Equipment Inventory Calculation Worksheet
- **6.** Att-Op-4F, Procedure for Use, Maintenance and Removal of Personal Protective Equipment (PPE)

**D.** Part E: Appendices
- **1.** None

**E.** Part F: Checklists
- **1.** Ck-Op-4, Infection Control Measures

# Op 5: Plan Activation

**Purpose**:

The purpose of this section is to define the activation of the Wisconsin Hospital Emergency Preparedness Plan (WHEPP) and supporting regional and internal hospital plans.

**Scope**:

The scope of this section will cover the circumstances under which the WHEPP will be activated.

**Concept of Operation**:

**A.** The WHEPP and supporting regional plans are to be activate base on an individual hospital exceeds or is on a pace to exceed their capability to successfully respond to an incident.

**B.** If an individual hospital is experiencing a surge of patients of this type and they have received no notification from a credible source that a bioterrorism or infectious disease incident is developing they are to take the following steps immediately:

**1.** Implement their appropriate internal procedures.

**2.** Tabulate the hospital's bed capacity and prepare to receive and manage bed capacity reports from other hospitals in the region.

**3.** Assume the role of "Base Hospital" and initiate notifications to the local Public Health Department and other hospitals in their region. Describe the situation experienced and the actions being taken.

**4.** Request support and interim stockpile materials if needed.

**5.** Prepare to send a hospital liaison to the County/Tribal Emergency Operating Center (EOC) and a public information officer to the County/Tribal Joint Information Center (JIC) in anticipation of the activation of these facilities.

## Op 5: Plan Activation

**C.** If an individual hospital is notified that one of the regional hospital is experiencing an escalating biological or infectious disease incident but are not experiencing it themselves take the follow steps immediately:

**1.** Gather the hospital decision makers needed to determine if internal procedures need to be implemented.

**2.** Notify all staff to enhance surveillance for the symptoms of biological or infectious disease agents.

**3.** Tabulate the current bed capacity and report it to the "Base Hospital." Initiate a continual assessment of bed capacity and report the results to the "Base Hospital" periodically.

**4.** Gather and prepare interim stockpile Personal Protective Equipment for possible shipment to affected hospitals.

**5.** Prepare to send a hospital liaison to the County/Tribal EOC and a public information officer to the County/Tribal JIC in anticipation of their activation.

**D.** If a notification is received that the County/Tribal EOC and/or JIC has been activated take the following steps:

**1.** Dispatch the hospital liaison and the public information officer to the County/Tribal EOC and JIC respectively.

**2.** When the liaison is in position and able to function there, direct all bed capacity and resource requests to the County/Tribal EOC.

**3.** When the public information officer is in position and able to function there, direct all information concerning hospital status and patient care to the County/Tribal JIC.

## Op 5: Plan Activation

**Related Documents**:

**A.** Legal:
- **1.** None

**B.** Part C: Resource Lists
- **1.** None

**C.** Part D: Attachments
- **1.** None

**D.** Part E: Appendices
- **1.** None

**E.** Part F: Checklists
- **1.** Ck-Op-5, Plan Activation

## Op 6: Hospital Receiving, Triage, and Transportation

**Purpose**:

The purpose of this section is to define Wisconsin Hospital Emergency Preparedness Plan (WHEPP) expectations concerning the receiving, triage, and transportation of patients upon arrival at the participant hospital.

**Scope**:

The scope of this section will address the application of hospital policies, hospital responsibilities and, if activated, interface with County/Tribal Emergency Operating Centers (EOC).

**Concept of Operation**:

**A.** Patient receiving, triage, and transportation are to be managed in accordance with the individual participant hospital's disaster or mass casualty plan and its transfer policies.

**B.** Hospitals that have transportation plans that rely solely on local Emergency Medical Services (EMS) are to have alternate plans if the incident circumstances dictate that all ambulances must be committed to the transport of patients from an incident scene.

**C.** If an EOC **has not** been activated:

**1.** It is the responsibility of each participant hospital to arrange for transportation of patients under their care through their own resources.

**2.** This is true whether the patient:

**a.** Has arrived from the incident scene and needed treatment from another hospital. OR

**b.** If a patient is in the hospital prior to the incident needs to be moved to make room for patients from the incident scene.

**D.** If an EOC **has been** activated, all transportation requests are to be coordinated through the hospital's EOC representative.

**Related Documents**:

**A.** Legal:
- **1.** None

**B.** Part C: Resource Lists
- **1.** None

**C.** Part D: Attachments
- **1.** Att-Op-6A, Field Medical Command
- **2.** Att-Op-6B, Patient Field Triage
- **3.** Att-Op-6C, Incident Termination

**D.** Part E: Appendices
- **1.** None

**E.** Part F: Checklists
- **1.** Ck-Op-6A, Hospital Receiving, Triage and Transportation
- **2.** Ck-Op-6B, Field Medical Command
- **3.** Ck-Op-6C, Patient Field Triage
- **4.** Ck-Op-6D, Incident Termination

# Op 7: Increasing Inpatient Bed Capacity

**Purpose**:

The purpose of this section is to provide guidance for increasing inpatient bed capacity during a bioterrorism event or other mass casualty event.

**Scope**:

The scope of this section will address patient assessment, methods to increase capacity, patient census determination, and staff augmentation issues.

**Concept of Operation**:

**A.** Assessment

**1.** If a hospital determines they are experiencing a bioterrorism event or other internal or external mass casualty event they are to use the following guidelines to assess and prepare for the need to increase bed capacity.

**2.** All inpatient and outpatient cases are to be assessed for the ability to discharge early, transfer to another care giver, or transfer to a different section of the hospital it self.

**3. In all cases,** a physician's assessment of patient care is required for the admission, treatment cancellation, early discharge, or transfer of any individual patient.

**4.** All attending physicians are to be contacted and informed of the need to increase inpatient bed capacity.

**5.** Each patient is to be assigned an acuity category.

**6.** The acuity level codes provided below are guidance for hospitals that do not already have an acuity level code system.

**a. Red** indicates inpatients which require critical care resources such as, life-sustaining medication, mechanical ventilation, and hemodynamic stabilization. These patients require continued hospitalization and advanced life support personnel for ambulance transfer. They will require placement in a critical care unit upon transfer.

**b. Yellow** indicates inpatients which require continued hospitalization, but do not require critical care resources during transfer and may be placed on a general inpatient unit. They may require ambulance transfer or patient transport vehicles.

**c. Green** indicates inpatients which are eligible for early discharge or may be cared for at home with home health care or in a nursing home setting. They may be transferred using private vehicles or patient transport vehicles.

**7.** The need for isolation rooms is to be assessed and their use prioritized. If isolation rooms are not available, plans to prevent the spread of infection are to be implemented according to the guidelines provided in section Op-4, “Infection Control Measures.”

**B.** Movement of patients outside a hospital facility

**1.** The emergency plans of participating hospitals are to provide for the transfer of patients to other hospitals or care facilities.

**2.** According to established diversion protocols, Emergency Departments are to divert patients to other area hospitals, urgent care clinics, or primary care clinics.

**3.** Hospitals are to have mutual aid agreements with other healthcare providers for transfer of critical patients to alternate intensive care units.

**C.** Movement of patients within the hospital facility.

**1.** Patients are to be transferred to other patient care units within a hospital to maximize overall bed capacity. Specifically, to free beds in rooms with negative pressure air flow.

**2.** Potential locations within hospitals may include but not limited to:

**a.** Private rooms are to be considered for conversion into semi-private rooms.

**b.** Previously closed patient care areas to be considered for re-opening to use as patient care areas.

**c.** Administrative areas of a hospital such as meeting rooms, waiting areas, etc., are to be evaluated for their potential use as patient care areas.

**D.** Determining and Communicating Patient Census and Bed Capacity

**1.** Hospitals are to designate an individual to complete and maintain a "Hospital Capacity and Patient Census Report" (See Attachment Att-Op-7A).

**2.** A bed capacity and patient census report form is to compile a record of:

**a.** Facility name
**b.** Facility location
**c.** Name of person completing the report
**d.** A phone number for this named person
**e.** The date the report was completed
**f.** The time the report was completed

**E.** Staff Augmentation

**1.** The hospital administrator or their designee, in conjunction with nursing, is to determine the adequacy of staffing for the event. The following considerations are to be made:

**a.** Staff who have been vaccinated against certain agents.

**b.** General staff safety and the need for prophylaxis or any prevention/treatment measures needed.

**c.** Staff qualification or testing for the proper use of Personal Protective Equipment.

**2.** Hospitals are to initiate their staff call-in procedures.

**3.** When staffing is insufficient to meet the increased patient load the need for additional staff is to be communicated to:

**a.** Other participating hospitals in the region or,
**b.** If activated, the County/Tribal Emergency Operating Center.

**4.** Hospital's emergency plan is to include a procedure for credentialing medical and nursing staff from other healthcare agencies during times of mass casualty events.

**Related Documents**:

**A.** Legal:
**1.** None

**B.** Part C: Resource Lists
**1.** None

**C.** Part D: Attachments
**1.** Att-Op-7A, Hospital Bed Capacity and Patient Census Report

**D.** Part E: Appendices
**1.** None

**E.** Part F: Checklists
**1.** Ck-Op-7, Increasing Inpatient Bed Capacity

**Op 8: Off-Site Facilities**

# To Be Developed

**Related Documents**:

**A.** Legal:
  **1.** None

**B.** Part C: Resource Lists
  **1.** None

**C.** Part D: Attachments
  **1.** None

**D.** Part E: Appendices
  **1.** None

**E.** Part F: Checklists
  **1.** None

# Op 9: Security

**Purpose**:

The purpose of this section is to address hospital security issues unique to a bioterrorism event or an infectious disease mass casualty event.

**Scope**:

The scope of this section addresses the key planning elements, pre-incident planning, and plan implementation.

**Concept of Operation**:

**A.** For a successful security response, there are three key planning elements that are to be incorporated into the participant hospital's security plan:

**1.** The plan is to be a written document based on a Hazards Vulnerability Analysis.

**2.** The plan is to be developed to effectively interface with an incident command organization.

**3.** Protocols for directing of patients, patient family members, media, and hospital response staff at the security check points are to be developed.

**4.** If streets outside of hospital grounds are to be barricaded, the method and type of barricading used is to be developed in conjunction with local law enforcement.

**5.** The plan is to allow sharing and integration with regional or county security plans.

## Op 9: Security

**B.** A successful security response is to include both pre-incident planning and plan implementation elements.

**1.** Pre-planning is to be developed based on a risk assessment method. Checklist Ck-Op-9, "Security" may be helpful as a start to this process.

**2.** Implementation of this plan is to include, but not limited to:

**a.** Notification and calling-in of security staff.

**b.** Perform a hospital lockdown that is to be implemented by one or a combination of the following means:

- ♦ Manually or automatically close designated doors and entrances.
- ♦ Dispatch security staff to security checkpoints.
- ♦ Place door signage.

**c.** Establish ingress and egress traffic paths inside the hospital and outside on hospital grounds.

## Op 9: Security

**Related Documents**:

**A.** Legal:
- **1.** None

**B.** Part C: Resource Lists
- **1.** None

**C.** Part D: Attachments
- **1.** None

**D.** Part E: Appendices
- **1.** None

**E.** Part F: Checklists
- **1.** Ck-Op-9, Security

# Op 10: Decontamination

**Purpose**:

This section provides guidelines that hospitals are to implement for the decontamination of patients.

**Scope**:

This section will provide guidance on: the three categories of decontamination, recommended minimum decontamination standards, and capacity and decontamination training specification.

**Concept of Operations**:

**A.** There are three Categories of decontamination that hospitals may be faced with:

1. Day-to-day/individual patient decontamination
2. Multiple casualty decontamination
3. Disaster/mass casualty decontamination

**B.** Hospitals are to meet the following recommended minimum decontamination standards:

**1.** Each hospital is to have decontamination equipment available and a Level C capability in accordance with Attachment Att-Op-10A, "Decontamination Personal Protective Equipment."

**2.** Every hospital is to have the capacity to decontaminate four ambulatory patients in 20 minutes.

**3.** Every hospital is to have to capacity to decontaminate two non-ambulatory patients in 20 minutes.

**C.** Hospitals are to have the following to meet the minimum decontamination capacity:

**1.** Those hospitals that do not have fixed decontamination capacity according to the specifications, as outlined in Attachment Att-Op-10B, "Specifications for Fixed Decontamination Rooms," are to have one two-line tent with water heater and a plan on how to accommodate increased numbers of patients in need of decontamination:

**a.** Plan Option One:

- ♦ Hospitals will use existing decontamination capacity to decontaminate patients, based on their existing fixed or portable decontamination stations.
- ♦ Hospitals will have an identified space for patients to disrobe.
- ♦ Hospitals will then triage patients into the decontamination station. This will necessitate the establishment of a holding area, especially in inclement weather conditions, for those patients both awaiting decontamination and also a holding area for "clean" patients, awaiting treatment.

**b.** Plan Option Two:

- ♦ Hospitals will use existing decontamination capacity to decontaminate patients based on their existing fixed or portable decontamination stations.
- ♦ Hospitals will establish a decontamination line in an appropriate area of the hospital to decontaminate patients. This option will also necessitate the establishment of a holding area for patients awaiting decontamination and also a holding area for "clean" patients awaiting treatment.

**2.** Those hospitals that have fixed decontamination capacity in accordance with Attachment Att-Op-10B, "Specifications for Fixed Decontamination Rooms," are to have one two-line tent with water heater.

**3.** If needed, hospitals will be supplied with additional decontamination equipment and tents from regional assets through County / Tribal Emergency Management.

**D.** Hospitals are to provide training for their staff in decontamination according to the curriculum provided in Attachment Att-Op-10C, "Minimum and Enhanced Specifications for Decontamination Curriculum."

## Op 10: Decontamination

**Related Documents**:

**A.** Legal:
- **1.** None

**B.** Part C: Resource Lists
- **1.** None

**C.** Part D: Attachments
- **1.** Att-Op-10A, Decontamination Personal Protective Equipment
- **2.** Att-Op-10B, Specifications for Fixed Decontamination Rooms
- **3.** Att-Op-10C, Minimum and Enhanced Specifications for Decontamination Curriculum

**D.** Part E: Appendices
- **1.** None

**E.** Part F: Checklists
- **1.** None

# Op 11: Disposal of Waste

**Purpose**:

The purpose of this section is to provide guidance for the safe disposal of infectious waste generated during a bioterrorism or infectious disease mass casualty event. **Note:** Protocols for chemical and radiological waste are under development. In the interim refer to your state, local or tribal Emergency Operating Procedures.

**Scope**:

The scope of this section will identify standard waste handling regulations, guidance on surge capacity, and guidance on storage considerations.

**Concept of Operation**:

**A.** Regulations and Statutes

**1.** During events when waste volumes have increased significantly, participating hospitals are to comply with established institutional plans as required by the Wisconsin Department of Natural Resources, Chapter NR 526, "Medical Waste Management." Existing federal and state waste disposal regulations and statutes are to be followed as these events unfold. Hospitals are also to contact local governmental agencies to determine local regulations.

**2.** Accurate record keeping is to be maintained as set forth in Chapter NR 526. Maintaining proper chain of custody documents may also be required by law enforcement.

**B.** Surge Capacity

**1.** In a mass casualty event, the potential for overloading the waste handling capacity of the hospitals is greatly increased.

**2.** Because of this potential, each participant hospital is to develop protocols in addition to existing waste management protocols that address the challenges associated with the increased volume of infectious waste.

**3.** A table providing guidance on the handling of infectious waste for various biological agents can be found in Attachment Att-Op-4B, "Guidelines for Patient Management."

**4.** Greater quantities of materials suitable for containing biological agents or infectious organisms will be needed. These materials are to include but not limited to:

- **a.** Biohazard labeled bags
- **b.** Sharps containers
- **c.** Liquid handling containers
- **d.** All other associated supplies materials

**5.** Hospitals are to list the supplies with supporting information that shows:

- **a.** The quantity normally on hand
- **b.** An estimate of how long these supplies will last for an inpatient population level determined by the hospital.

**6.** If the existing inventory of materials or usage rate compromises patient care or waste containment needs, the hospital is to obtain additional material:

**a.** If an Emergency Operation Center (EOC) is not activated, contact other participant hospitals and request the materials needed.

**b.** If the EOC is activated, contact the EOC and request the materials needed. The EOC may obtain materials from:

- Participant hospitals
- Other known sources
- The State of Wisconsin by submitting a request for materials from the Centers for Disease Control (CDC), "Vendor Managed Inventory Program"

**C.** Storage:

**1.** Hospitals are to consult with their medical waste disposal vendors for details of the vendor's ability to provide continued waste disposal services during a mass casualty emergency.

**2.** Hospitals are to consult with their County/Tribal Emergency Management office for protocols for storage of infectious waste during a mass casualty incident.

**3.** Infectious waste may need to be stored under refrigeration (<42°F) to limit nuisance conditions.

**a.** If the EOC is not activated, hospitals are to contact the County/Tribal Emergency Management office to obtain refrigerated storage.

**b.** If the EOC is activated, hospitals are to contact the EOC to obtain refrigerated storage.

**4.** Separation of infectious waste from the solid waste stream is to be maintained.

**5.** Combined waste streams are to be handled as infectious waste.

**6.** Chemical and radiological wastes must be separated and segregated from infectious waste in order to avoid dual contamination.

**7.** Waste stored on the premises of the hospital must be secure to prevent access by unauthorized persons and to prevent accidental spread of contamination.

**8.** The designated storage area for infectious waste must display the appropriate 'bio-hazard' symbols.

**9.** Refrigerated storage areas need to be located away from external air intakes or they need to be maintained with negative airflow.

## Op 11: Disposal of Waste

**Related Documents**:

**A.** Legal:
- **1.** None

**B.** Part C: Resource Lists
- **1.** None

**C.** Part D: Attachments
- **1.** None

**D.** Part E: Appendices
- **1.** None

**E.** Part F: Checklists
- **1.** Ck-Op-11, Disposal of Waste

# Op 12: Interim Stockpile

A. **Purpose**: The purpose of the Regional Hospital Bioterrorism Preparedness Interim Stockpile Plan (ISP) is two-fold: first, to enhance the ability of Regional Hospital Bioterrorism Preparedness Teams to provide necessary medical supplies, medications and vaccines for interim care of victims of a biological release prior to the arrival of the Strategic National Stockpile. Secondly, this plan will provide a base structure for pharmaceutical and equipment response in the event of chemical terrorism or a natural disaster. Biological response planning is based on adequate supplies for a period of 48 hours after identification of a bioterrorism incident. Stockpile contents are intended for treating those casualties that have been exposed, as well as, protecting essential personnel. Essential personnel are defined as EMS, Fire, Law Enforcement, Public Health, Emergency Management and other critical Governmental personnel, Hospital and Transportation personnel and their families.

B. **Scope**: This document is meant to be used as a template. Regional variation in population and resources will need to be considered when developing a plan.

C. Stockpile Plan

1. The Stockpile Oversight Committee will manage the stockpile. The Stockpile Oversight Committee will be a sub-committee of the Regional Hospital Bioterrorism Preparedness Committee and may include the following disciplines:

    a. Regional Hospital Bioterrorism Preparedness Team Representative
    b. Pharmacist
    c. Physician
    d. Stockpile Site Representative(s)
    e. Regional Emergency Management
    f. Public Health

2. Stockpile Oversight Committee Responsibilities

    a. Meet as needed to implement planning; annually, at a minimum, thereafter
    b. Identify and approve stockpile sites
    c. Create memorandums of agreement with stockpile sites
    d. Work with Public Health and Emergency Management to integrate plans
    e. Determine Stockpile Implementation Plan and Release Authorities appropriate to the region
    f. Maintain overall accountability of stockpile contents
    g. Manage stock rotation issues
    h. Manage replacement of outdated materials
    i. Implement State recommended changes to stockpile content

3. Regional Stockpile Site Selection

    a. Stockpile Oversight Committee will designate one or more stockpiles as is appropriate for the region. Stockpile management will be easier with one or two sites, but several institutions may need to be considered when looking at region dynamics.
    b. When selecting a stockpile facility, a local hospital(s) may be able to more readily accommodate the selection criteria. Alternatively, a local pharmacy(ies) may be considered.

4. Selection Criteria

    a. Agreement of the designated Stockpile Site to serve as an inventory and distribution site
    b. Ability of the Stockpile Site to have space available to maintain an inventory.
    c. Ability of the Stockpile Site to rotate inventory stocks so that no medications will surpass their expiration date
    d. Ability of the Stockpile Site to package and label pharmaceuticals for individual disbursement
    e. Ability of the Stockpile Site to have pharmaceuticals ready for transportation so that pharmaceuticals will reach distribution sites within 6 hours
    f. Ability of the Stockpile Site to maintain the stockpile in a safe and secure location.
    g. Ability of the Stockpile Site to provide adequate security to protect the inventory and personnel working with the inventory should an incident occur.
    h. Ability of the Stockpile Site to provide a plan to inventory the contents annually and submit an annual inventory report to the Stockpile Oversight Committee.

## D. Pharmaceutical Stockpile

1. Content recommendations are located in Appendix 18-B. The contents of the Stockpile shall be consistent with State and CDC recommendations. Stockpile content will be reviewed annually.

2. Quantities for the Stockpile are determined based upon the following recommendations: for every 400,000 population there should be adequate quantities of antibiotics to provide prophylaxis for 10,000 victims for up to the first 48 hours.

Planning for chemical weapon antidote should adequately cover 1000 victims per 400,000 population.[1]

3. Regions, containing Metropolitan Medical Response System (MMRS) Cities, should base their calculations on the regional population excluding the MMRS population.[2] Those regions containing MMRS Cities (Milwaukee and Madison) will need to address cooperative planning with the MMRS Committees.

4. Specific inventory lists should be maintained as an appendix to plan.

## E. Accessing Regional Pharmaceutical Stockpile

1. Situation: The Interim Stockpile consists of pharmaceuticals and medical equipment to be established for regional use in response to a biological incident within the designated region.

2. Assumptions for Activation of Interim Stockpile Plan:

   a. A biological release (or other mass casualty event) has occurred and it has been determined that the Interim Stockpile contents are necessary for immediate response.

   b. The contents of the Interim Stockpile are to be released only when there is mutual agreement between the requesting hospital and the local health department.

   c. Emergency Management Office is to be informed by the local health department as soon as the decision is made and should be involved in the decision-making process, if time and the situation permit.

## F. Distribution

1. The approved Interim Stockpile sites will release their inventory for transport and/or distribution upon notification from the requesting hospital or the local health department, assuming that there is mutual decision to do so as outlined in Paragraph E.2.b.

2. Medications will be dispensed in accordance with the Interim Stockpile and/or Public Health Plan.

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[1] Based on U.S. Department of Health Metropolitan Medical Response System (MMRS) pharmaceutical recommendations.

[2] MMRS cities already have pharmaceutical stockpiles to provide treatment/prophylaxis for their existing population base.

G. **Receiving the Stockpile**: Upon receiving the distributed inventory from the Stockpile, each designated dispensing site will be accountable for maintaining a receipt and record of stockpile contents and content distribution. A copy of this record is to be provided to the Stockpile Oversight Committee within 10 days following Stockpile distribution and dispensing.

**Related Documents**:

**A.** Legal:
- **1.** None

**B.** Part C: Resource Lists
- **1.** None

**C.** Part D: Attachments
- **1.** Att-Op-12A, Document Glossary
- **2.** Att-Op-12B, Biological Critical Medical Material Order
- **3.** Att-Op-12C, Chemical Antidotes (*for future consideration*)
- **4.** Att-Op-12D, Treatment Protocols (*for future consideration*)
- **5.** Att-Op-12E, Checklists for Establishing a Regional Stockpile

**D.** Part E: Appendices
- **1.** None

**E.** Part F: Checklists
- **1.** Ck-Op-12, Interim Stockpile

**Op 13: Special Needs Patients**

## To Be Developed

**Related Documents**:

**A.** Legal:
- **1.** None

**B.** Part C: Resource Lists
- **1.** None

**C.** Part D: Attachments
- **1.** None

**D.** Part E: Appendices
- **1.** None

**E.** Part F: Checklists
- **1.** None

# Op 14: Risk Communication

Note: "Risk Communications" refer to any communications provided by a public authority during a disaster incident.

## A. Communications With the Media:

1. **State-Wide Communications**: The following protocols are to be implemented when the State Emergency Operations Center and the Joint Information Center (JIC) (see Appendix 19-A) are activated. During a major incident, all media communications are to be conducted through the JIC, located at the State Emergency Operations Center.

    a. The JIC will issue all press releases and conduct all news conferences.

    b. Public information responsibilities are shared among the State of Wisconsin, the affected organizations (e.g. hospitals, local health departments, Emergency Management, etc.) and the federal government. The common goals of all of these agencies, through the development and implementation of this plan are:

        1) to protect the health and welfare of the public by communicating emergency information in a timely and accurate manner;

        2) to minimize public concern and confusion about the incident;

        3) to maintain public confidence in the ability of government to mitigate and minimize the impact of the incident. This is to be accomplished by providing emergency information that is correct, consistent and credible, and by doing so promptly and openly.

    c. The Joint Information Center (JIC) is the primary entity, responsible for accomplishing these goals.

    d. The hospital representative at the State EOC will assist the JIC in communications regarding hospitals.

2. **Local Communications:** The following protocols are to be implemented when the State Emergency Operations Center and the Joint Information Center (JIC) are activated and also when only the City/County EOC is activated:

    a. During a major incident, all media communications are to be conducted through the City/County EOC.

    b. Hospitals may release to the City/County EOC the condition of patients, being treated at their facility, according to established hospital protocols.

    c. Public information will be made available through the Wisconsin Division of Public Health (DPH) in multiple languages to reach affected populations. The languages, for which public information is prepared, are:

        1) English
        2) Spanish
        3) Hmong

    d. The JIC will provide information regarding

        1) the establishment of and access to patient evaluation centers, acute care centers, off-site treatment facilities, dispensing sites, etc. to direct patients towards appropriate levels of care so that resources are utilized appropriately

        2) specific directives about where to seek appropriate levels of care and service

        3) public service announcements

        4) quarantine or shelter-in-place advisories

        5) information regarding the illnesses and injuries that may be caused by the incident

        6) the status of the incident and the termination of the incident.

    e. The City/County EOC will provide information to be relayed to the media, if the JIC has not yet been activated, regarding A.2.d.1) through A.2.d.6).

## B. Communications with Healthcare Providers

1. **State-Wide Communications**: The following protocols are to be implemented when the State Emergency Operations Center and the JIC are activated:

    a. The hospital representative at the State EOC is to notify healthcare providers that the State Hospital Plan has been activated.

    b. The Wisconsin Division of Public Health is to provide healthcare providers the following information:

        1) information regarding the symptomology, diagnosis and treatment of illnesses or injuries that may be caused by the incident

        2) contact information for access to consultants

        3) information for distribution for patients regarding the illnesses or injuries that may be caused by the incident

2. **Local Communications**: The following protocols are to be implemented when the State Emergency Operations Center and the JIC are activated and also when only the City/County EOC is activated:

    a. The hospital representative at the City/County EOC is to notify healthcare providers that the State Hospital Plan has been activated.

    b. The Wisconsin Division of Public Health is to provide healthcare providers the following information:

        1) information regarding the symptomology, diagnosis and treatment of illnesses or injuries that may be caused by the incident

        2) contact information for access to consultants

        3) information for distribution for patients regarding the illnesses or injuries that may be caused by the incident

## Op 14: Risk Communication

**Related Documents**:

**A.** Legal:
- **1.** None

**B.** Part C: Resource Lists
- **1.** None

**C.** Part D: Attachments
- **1.** None

**D.** Part E: Appendices
- **1.** None

**E.** Part F: Checklists
- **1.** Ck-Op-14, Risk Communication

# Op 15: Responder Workforce

## Part A: Licensed Healthcare Professionals

1. The list of all healthcare professionals, licensed by the State of Wisconsin, is maintained on the Wisconsin Health Alert Network (HAN) on a restricted access site. In addition, the Physician Profile of the American Medical Society is also housed at the same restricted access site.

    a. The licensure database, on the HAN, shall be up-dated annually by the Wisconsin Division of Public Health, Hospital Bioterrorism Preparedness Program on July 1.

    b. The AMA Physician Profile, on the HAN, shall be up-dated annually by the Wisconsin Division of Public Health, Hospital Bioterrorism Preparedness Program on July 1.

    Note: For the purpose of disaster credentialing of physicians, it is not necessary to access data from the National Practitioner Database or to complete a criminal background check.

2. These two databases have restricted access and can only be accessed when the State of Wisconsin Hospital Plan is activated. Access is available only to the hospital representative(s) at the City/County EOC and to hospitals, requesting this access so that they can credential licensed healthcare professionals, who come directly to the hospital.

3. The database can be sorted by

    a. licensed profession
    b. specialty
    c. zipcode
    d. county

4. The licensed healthcare professionals that can be accessed through the Department of Regulation and Licensing database are found in Appendix 23-A.

    Note: Post Graduate 1 Residents (PG1) are not yet licensed.

5. All requests for licensed healthcare professionals to be deployed will be managed through the City/County Emergency Operations Center or the State Emergency Operations Center (See Part D). However, hospitals retain the right to credential licensed healthcare professionals, who come directly to the hospital, according to their Emergency Credentialing protocols.

    a. Hospitals seeking licensed healthcare professionals are to contact the City/County EOC and request licensed healthcare professionals by completing the "Licensed Responder Workforce Deployment Request, Part A":

        1) Profession requested
        2) Specialty requested

    b. Licensed healthcare professionals, responding to the deployment request, will be instructed to contact the City/County or State EOC. They will then be given instructions regarding to which facility they will be deployed.

    c. Licensed healthcare professionals, who present at a hospital, are not to be deployed until the City/County EOC or the hospital, to which licensed healthcare professionals come directly, completes the credentialing and licensure verification process.

6. The EOC shall report on the "Licensed Responder Workforce Deployment Request, Part B" the following information:

    a. Licensure Verification
    b. Verification of Training/Competency (for physicians only)
    c. Estimated Time of Arrival (ETA) at the requesting organization
    d. Estimated Length of Service (ELOS) at the requesting organization
    e. License Number
    f. DEA Number
    g. UPIN Number

7. Hospitals, receiving deployed licensed healthcare professionals from the City/County EOC, are to report to the EOC the status of the deployed licensed healthcare professionals on the "Licensed Responder Workforce Deployment Request, Part C" on the hour. Hospitals shall also report on Part C any licensed healthcare professionals, who are credentialed by the hospital.

8. Upon arrival at the requesting hospital, as proof of their identity, deployed licensed health care professionals shall provide their valid State of Wisconsin Driver's License or Organization ID Badge with Photograph and shall sign the "Deployment of Licensed Healthcare Professionals Agreement", whereby they agree to:

    a. to abide by policies and procedures of the organization

    b. to abide by the Medical Staff By-laws and Rules and Regulations (physicians and allied health professionals only)

    c. to abide by the emergency policies and procedures of the organization

9. Healthcare professionals shall self-identify the following upon arrival at the requesting organization.

    a. Physicians shall self-identify their:

        1) Residency Status and Level of Residency (PG 2 through PG7)
        2) Critical-Care Capability

    b. Other licensed healthcare professionals shall self-identify

        1) specialty
        2) special training and competencies

**Part B: Out-of-State Licensed Healthcare Professionals**

*This Part B is under development*

## Part C: Non-Licensed Healthcare Workers and Volunteers

1. All requests for non-licensed healthcare workers and volunteers to be deployed will be managed through the City/County Emergency Operations Center or the State Emergency Operations Center (see Part D). However, hospitals retain the right to deploy non-licensed healthcare professionals, who come directly to the hospital, according to their own protocols.

    a. Hospitals seeking non-licensed healthcare workers and volunteers are to contact the City/County EOC and request the types of non-licensed healthcare workers and volunteers needed by completing the "Non-Licensed Responder Workforce Deployment Request, Part A".

    b. Non-licensed healthcare workers and volunteers, responding to the deployment request, will be instructed to contact the City/County or State EOC. They will then be given instructions regarding to which facility they will be deployed.

    c. Non-licensed healthcare professionals, who present directly at a hospital, may be deployed after completion by the site coordinator of the "Non-Licensed Responder Workforce Deployment Request, Part B".

2. The EOC shall report on the "Non-Licensed Responder Workforce Deployment Request, Part B" the following information:

    a. Training/Competency (Usual Job Title and/or Responsibility)
    b. Estimated Time of Arrival (ETA) at the requesting organization
    c. Estimated Length of Service (ELOS) at the requesting organization
    d. Current Employer
    e. Current Job Title or Job Responsibilities

3. Hospitals, receiving deployed non-licensed healthcare workers or volunteers from the City/County EOC, are to report to the EOC the status of the deployed non-licensed healthcare workers or volunteers on the "Responder Workforce Deployment Request, Part C" on the hour. Hospitals shall also report on Part C any non-licensed healthcare professionals or volunteers, who are deployed by the hospital.

10. Upon arrival at the requesting hospital, as proof of their identity, deployed non-licensed health care workers or volunteers shall provide their valid State of Wisconsin Driver's License or Organization ID Badge with Photograph and shall sign the "Deployment of Licensed Healthcare Professionals Agreement", whereby they agree to:

    a. to abide by policies and procedures of the organization

    b. to abide by the emergency policies and procedures of the organization

4. Non-licensed healthcare workers and volunteers shall self-identify their training and competencies (normal job titles or responsibilities upon arrival at the requesting organization.

**Part D: Recruitment of the Responder Workforce**

*This Part B is under development*

**Related Documents**:

**A.** Legal:
- **1.** None

**B.** Part C: Resource Lists
- **1.** None

**C.** Part D: Attachments
- **1.** None

**D.** Part E: Appendices
- **1.** None

**E.** Part F: Checklists
- **1.** Ck-Op-15, Response Workforce

## Op 16: Training and Education

A. The State of Wisconsin will provide on an annual basis the Core Curriculum for BOIDOOPHTE. This Core Curriculum is developed based on recommendations from Public Health Consortia, Regional Hospital Bioterrorism Preparedness Teams, information provided by agencies such as CDC, HRSA, APIC and from the assessments distributed through the Health Professions and Education Coalition. The Core Curriculum will outline the

   1. the courses available
   2. core competencies
   3. methodologies to access the course
   4. proficiency testing
   5. reporting capabilities

B. The State of Wisconsin will present its Core Curriculum at the beginning of the federal Fiscal Year, i.e. September.

C. The Regional Hospital Bioterrorism Preparedness Steering Committees are to make recommendations on any aspects of Training/ Education to the Program Director. The Program Director shall make these recommendations to the CDC Focus Area G Training/Education Coordinators under whom all training and education for BOIDOOPHTE is coordinated.

D. The Regional Steering Committees may develop other courses as they determine necessary and which may not be able to be offered under the Core Curriculum. It is recommended, however, that all training/education be reviewed by the CDC Focus Area G Training/Education Coordinators so that

   1. all curriculum is standardized across the State of Wisconsin
   2. course offerings developed by the Regional Hospital Bioterrorism Preparedness Steering Committees be considered for adoption by the State as Core Curriculum.

## Op 16: Training and Education

**Related Documents**:

**A.** Legal:
- **1.** None

**B.** Part C: Resource Lists
- **1.** None

**C.** Part D: Attachments
- **1.** None

**D.** Part E: Appendices
- **1.** None

**E.** Part F: Checklists
- **1.** Ck-Op-16, Training and Education

**Op 17: Communication**

## To Be Developed

**Related Documents**:

**A.** Legal:
  **1.** None

**B.** Part C: Resource Lists
  **1.** None

**C.** Part D: Attachments
  **1.** None

**D.** Part E: Appendices
  **1.** None

**E.** Part F: Checklists
  **1.** None

**Op 18: Physician's Offices & Clinics**

## To Be Developed

**Related Documents**:

**A.** Legal:
- **1.** None

**B.** Part C: Resource Lists
- **1.** None

**C.** Part D: Attachments
- **1.** None

**D.** Part E: Appendices
- **1.** None

**E.** Part F: Checklists
- **1.** None

# Att-Ad-1A: Membership

## Purpose

The purpose of this attachment is to define the membership needed to form the Health Resources and Services Administration (HRSA) Leadership Committee and Regional Boards.

## Scope

This attachment will describe the governing and supporting responsibilities. It will also define the working relationship between the Leadership Committees and the individual Regional Boards.

## Concept of Operation

**A.** The Leadership Committee

**1.** This committee is comprised of the following positions:

**a.** A Chairperson – the Director, Hospital Bioterrorism Preparedness, Division of Public Health.

**b.** Voting Members – the Chairpersons or the Vice-Chairpersons from each of the 7 HRSA Regions within the State of Wisconsin.

**c.** Supporting Members –

- Regional project coordinators
- Subject matter experts as needed

**2.** The Leadership Committee will define program deliverables, evaluate input from designated expert panels and regional steering committees, determine policy and approve changes to the Wisconsin Hospital Bioterrorism Preparedness Plan (WHEPP).

**B.** The Regional Boards

**1.** The Boards are comprised of the following positions:

**a.** A Chairperson – one of the hospital representatives.

**b.** A Vice-Chairperson – one of the hospital representatives.

**c.** A Fiscal Agent - a member with the authority and ability of administer funds received and expended in the name of the WHEPP.

**d.** A Representative - from each participating hospital in the region.

**e.** A Project Coordinator (optional)

**f.** A Recorder (optional)

**g.** Supporting Members – are to include but not limited to:

- Regional Health departments
- Regional Emergency Management
- Regional Emergency Medical Services

**2.** The regional Boards will implement the WHEPP within their region and within the means and capabilities of that region. They will supply input to the Leadership Committee on WHEPP content and policies.

**3.** The members of the regional Boards are composed of all organizations necessary to respond to a disaster of this nature and when any individual institution's capacity is exceeded. These institutions include Hospitals, Local Health Departments, Emergency Management Offices, Emergency Medical Services, Physicians Offices and other organizations deemed necessary by the committee.

**4.** Because the WHEPP is written to meet the needs of the public without regard for regional or State borders, individual institutions may identify their working relationship to one or a number of regional Boards. Individual institutions are to identify themselves as a "primary member" or "affiliate member" of a given regional Board. Primary membership implies that the institution's base and operating location is within one or more of the counties within a given Wisconsin HRSA region. Affiliate membership implies that the institution provides services or more closely operates within a region other than the one in which they are based. The latitude to choose membership and participation is defined as follows:

**a.** Participant institutions have the right to choose which regional Board they consider as their "primary" Board.

**b.** Participant institutions have the right to choose which regional Board they consider as their "affiliate" Board.

**c.** Participant institutions have the right to choose as their "primary" or "affiliate" a Board located in a border state.

**d.** Participant institutions choosing a "primary" regional Board in a border state are to identify an "affiliate" Board in a Wisconsin region.

**5.** Primary and Affiliate members of the regional Boards are found in Part C, Resource Lists.

# Att-Ad-3A: Writer's Guide

## Purpose

The purpose of this document is to define the format for the Wisconsin Hospital Emergency Preparedness Plan (WHEPP) and a recommended revision tracking methodology.

## Scope

This document will address the structure and format of the WHEPP: Header and Footer; Table of Content, Glossary, Acronym and Legal Tab; Parts and Sections. It will also provide a methodology for tracking revisions.

## Headers and Footers

**A.** The header of each page is to contain:

**1.** The plan title, "Wisconsin Hospital Emergency Preparedness Plan" (Font: Times New Roman, Font style: normal and Size: 12)

**2.** The topic title for each legal document, section, Attachment, Appendix, Resource Category or Checklist. (Font: Times New Roman, Font style: bold and Size: 12)

**Att-Ad-3A: Writer's Guide**

**B.** The footer of each page is to contain:

**1.** A centered page number using the following format were (Font: Times New Roman, Font style: normal and Size: 12):

**a.** The first identifier is the abbreviation for the type of document it is:

- Table of Content (ToC)
- Glossary / Acronyms (G/A)
- Legal (L)
- Administration (Ad)
- Operation (Op)
- Attachment (Att)
- Appendix (Apx)
- Resource Coordination (Rc)
- Checklist (Ck)

**b.** The second identifier is the sequential number of the document.

**c.** The third identifier is a sequential page number.

Example: Sec 12 - 1

**2.** A left justified version and revision date (Font: Times New Roman, Font style: normal and Size: 10):

**a.** Version number (i.e., a sequential whole number – 1, 2, 3, etc.)

**b.** The revision date for the version listed (i.e., mm-dd-yyyy)

Example: Version: 2
Date: 07-09-2004

**Att-Ad-3A: Writer's Guide**

## The Table of Content

**A.** The Table of Content (ToC) provides a separate table for each "Part" of the plan, including a table for the table of content, glossary / acronyms, and legal section.

**B.** The table for the table of content, glossary, acronyms and legal tab will have the following three column headings in the following order:

1. Title
2. Version No.
3. Revision Date

**C.** Each "Part" will be designated by a sequential capital letter and have its own title.

1. The respective tables will have the following four column headings:
   - **a.** The first column will have one of the following headings as is appropriate:
     - ♦ Section (for Parts A & B)
     - ♦ Category (Part C)
     - ♦ Attachment (Part D)
     - ♦ Appendix (Part E)
     - ♦ Checklist (Part F)
   - **b.** The second column heading will be the document Title.
   - **c.** The third column heading will be the document Version Number.
   - **d.** The fourth column heading will be the version number Revision Date.

## Att-Ad-3A: Writer's Guide

### Glossary / Acronyms

**A.** The glossary and acronym of this plan is to be similar to that of the Wisconsin Public Health Emergency Plan.

**B.** Common and unique terms within and between both plans are to be included.

### Legal section

**A.** This section will provide a location to insert or list specific legal or regulatory documents pertinent to the operation of Wisconsin hospitals during a biological agent or infectious disease mass casualty incident.

**B.** The identifier for each document is to begin with a "L" and then a sequential number for each new document or list added.

Example: L-1, L-2 etc.

### Plan "Parts"

**A.** Part A, Administration (Ad)

**1.** Ad 1: Introduction (includes but not limited to):

**a.** The Plan purpose and scope

**b.** Administrative oversight and authority

**c.** Historical bases or background

**d.** The operational relationship to State and County Standard Operation Procedures, Annex H "Health and Medical."

**2.** Ad 2: Post Incident Evaluation

**3.** Ad 3: Plan Approval

**4.** Each document in this Part is to have a unique identifier.

**a.** The prefix is to be "Ad"

**b.** Followed by the number of the section as defined above

EXAMPLE: Ad-1, Ad-2, etc.

**B.** Part B, Operations

**1.** Op 1: Surveillance

**2.** Op 2: Identification of an Unusual Infectious Disease or Incident of Bioterrorism

**3.** Op 3: Notification of an Incident

**4.** Op 4: Infection Control Measures

**5.** Op 5: Plan Activation

**6.** Op 6: Hospital Receiving, Triage and Transportation

**7.** Op 7: Increasing Inpatient Bed Capacity

**8.** Op 8: Off-Site Facilities

**9.** Op 9: Security

**10.** Op 10: Decontamination

**11.** Op 11: Disposal of Waste

**12.** Op 12: Interim Stockpile

**13.** Op 13: Special Needs Patients

**14.** Op 14: Risk Communication

**15.** Op 15: Response Work Force

**16.** Op 16: Training and Education

**17.** Op 17: Communication

**18.** Op 18: Physician's Offices & Clinics

**19.** Each document in this Part is to have a unique identifier.

- **a.** The prefix is to be "Op"
- **b.** Followed by the number of the section as defined above

  EXAMPLE: Op-1, Op-2, etc.

**C.** Part C, Resource Coordination

**1.** To be consistent with State and FEMA preparedness document definitions, the content of this part should include, but not limited to, the following categories of resources:

- **a.** Push packs
- **b.** Vendor managed inventories
- **c.** Interim stockpile inventories
- **d.** Chemical packs
- **e.** Pharmaceuticals
- **f.** Regionally stored supplies

**2.** The content of each resource category listed is to have at least the following supporting information:

- **a.** Description of the resource
- **b.** Where appropriate, equipment:
  - ♦ Model Number
  - ♦ Specifications
  - ♦ Stock or Lot Number
- **c.** Storage location
- **d.** Contact information to obtain the resource

**3.** Lists of contact information for notification and information flow are to be maintained on a regional, county, or individual hospital level as determined by the respective regional HRSA Boards.

**4.** Each document in this Part is to have a unique identifier.

**a.** The prefix is to be "Rc"

**b.** Followed by the number of the section it is related to.

**c.** Followed by a sequential capital letter starting with "A" for each document related to the given "Section."

EXAMPLE: Rc-12A, Rc-12B, etc.

**D.** Part D, Attachments

**1.** The documents in this "Part" of the Plan are defined as forms, charts, and tables or information text that relate specifically to a given "Section" in the Plan.

**2.** Each document in this "Part" is to have a unique identifier.

**a.** The prefix is to be "Att"

**b.** Followed by the number of the "Section" it is related to.

**c.** Followed by a sequential capital letter starting with "A" for each document related to the given "Section."

EXAMPLE: Attch-12-A, Attch-12-B, etc.

**E.** Part E, Appendices

**1.** The documents in this "Part" of the Plan are defined as supporting or related plans from other agencies or organizations.

**2.** Each document in this "Part" is to have a unique identifier.

**a.** The prefix is to be "Apx"

**b.** Followed by the number of the "Section" it is related to.

**c.** Followed by a sequential capital letter starting with "A" for each document related to the given section.

EXAMPLE: Apx-12A, Apx-12B, etc.

**F.** Part F, Section Evaluation Checklists

**1.** This "Part" contains a series of checklists. One or more or no checklist(s) may be developed for a given Plan section.

**2.** Each document in this Part is to have a unique identifier.

**a.** The prefix is to be "Ck"

**b.** Followed by the number of the section it is related to.

**c.** A sequential capital letter starting with "A" may be added if there are multiple checklists for a given section.

EXAMPLE: Ck-3, Ck-4A, Ck-4B, etc.

**Att-Ad-3A: Writer's Guide**

## The Administration and Operation Sections

**A.** Each section of the Plan will have four components. They will include:

1. A purpose statement
2. A scope statement
3. A concept of operation listing
4. A related documents listing

**B.** The **Purpose** is a brief statement, one or two sentences in length that describes for the reader why this section is written.

**C.** The **Scope** is a brief description of the topics or issues that will be addressed in the Concept of Operation section to meet the purpose statement.

**D.** The **Concept of Operation** provides the direction, expectations and detail needed to address the topics or issues identified in the scope statement.

1. The format for these components is to be an outline form as follows:

A. "Topic or issue description"

1. "Key points"

a. "Sub-points"

♦ "Detail"

**2.** This format should be adequate for describing the information for any given topic or issue, however, this format may be adjusted to meet the needs of the information being provided. For example: tables, charts or diagrams may be inserted as is appropriate.

**3.** However, deviating repeatedly from the base outline format can compromise the reader's ability to quickly obtain information from the text.

**E.** The **Related Documents** provides a listing of attachments, appendices, resource categories, checklists or legal documents that relate to a given section.

**1.** There is to be one topic heading for each of the Plan "Parts" that will include:

- **a.** Legal
- **b.** Part C, Resource Lists
- **c.** Part D, Attachments
- **d.** Part E, Appendices
- **e.** Part F, Checklists

**2.** Each related document is to be listed under the appropriate topic heading.

**3.** Each entry is to include the unique identifier and the title.

**Review & Revision Method Recommendations**

**A.** Within the right margin of a revised page, a revision bar should be printed to draw the attention of the reader.

**1.** The appearance of revision bars will signify where, on the page, the text or information has changed from that of the previous version. Therefore, prior vision bars are to be deleted.

**2.** If the entire section has been substantially revise a statement in the revision cover letter can be made to identify this fact and then no revision bars are needed.

**B.** To avoid an administrative burden of maintaining a tracking record of individual page changes, this Writer's Guide recommends that an entire section be re-printed and issued whenever a change to that section has been made. By doing this, the version number and revision date can be consistently listed at the bottom of each section page and match the revision number and date published in the Table of Content.

**C.** A revised Table of Content is to be issued whenever a legal, administration, operation, attachment, appendix, resource category, or checklist document has been added, revised or deleted.

**D.** Finally, this Writer's Guide recommends that a revision cover letter be provided with each distributed revision to the Plan. This letter should include:

**1.** A brief description and reasoning behind the changes made. (i.e., lessons learned, new program guidance or scope, new technology)
**2.** A table that shows what section(s) and version to be "removed" and the section(s) and version to be "inserted."
**3.** A contact who can give insight into the change, should the reader request it.

## Att Op 1A: Category I, II and III Reportable Diseases

Note: Certain changes have been made in these tables that presently do not appear on the DOH 4151

| Category I Diseases, which are to be reported IMMEDIATELY |
|---|
| **Anthrax (Category A)** |
| **Botulism (Category A)** |
| Botulism, infant |
| **Cholera (Category B)** |
| *Diphtheria |
| **Foodborne/waterborne outbreaks (Category B)** |
| *Haemophilus influenzae invasive disease, (including epiglottitis) |
| Hantavirus |
| *Hepatitis A |
| *Measles |
| Meningococcal disease |
| Pertussis (whooping cough) |
| **Plague (Category A)** |
| *Poliomyelitis |
| Rabies (human) |
| **Ricin toxin (Category B)** |
| *Rubella |
| Rubella (congenital syndrome) |
| **Smallpox (Category A)** |
| Tuberculosis |
| **Tularemia (Category A)** |
| **Viral hemorrhagic fevers (Category A)** |
| Yellow fever |

* Vaccination history is also required

## Att Op 1A: Category I, II and III Reportable Diseases

| **Category II Diseases, which are to be reported AS SOON AS POSSIBLE, BUT NO LATER THAN 72 HOURS** |
|---|
| Amebiasis |
| Arboviral infection (encephalitis/meningitis) |
| Babesiosis |
| Blastomycosis |
| **Brucellosis (Category B)** |
| Campylobacter |
| Cat Scratch Disease (Bartonella species) |
| Chancroid (STD) |
| Chlamydia trachomatis infection (STD) |
| **Clostridium perfringens (Category B)** |
| **Cryptosporidiosis (Category B)** |
| Cyclosporiasis |
| Ehrlichiosis |
| **Encephalitis, viral (other than arboviral) (Category B)** |
| **E. coli 0157:H7 (Category B)** |
| **Other enterohemorrhagic E. coli (Category B)** |
| **Enteropathogenic E. coli (Category B)** |
| **Enteroinvasive E. coli (Category B)** |
| **Enterotoxigenic E.coli (Category B)** |
| Giardiasis |
| Gonorrhea (STD) |
| Hemolytic uremic syndrome |
| Hepatitis B |
| Hepatitis C |
| Hepatitis non–A, non–B, (acute) |
| Hepatitis D |
| Hepatitis E |
| Herpes Simplex Virus (first genital episode identified by health care provider) (STD) |
| Histoplasmosis |
| Kawasaki disease |
| Legionellosis |
| Leprosy (Hansen Disease) |
| Leptospirosis |
| Listeriosis |
| Lyme disease |
| Malaria |
| **Melioidosis (Category B)** |
| Meningitis, bacterial (other than Haemophilus influenzae or meningococcal) |
| Meningitis, viral (other than arboviral) |

## Att Op 1A: Category I, II and III Reportable Diseases

| **Category II Diseases, which are to be reported AS SOON AS POSSIBLE, BUT NO LATER THAN 72 HOURS** (continued) |
|---|
| Mumps |
| Mycobacterial disease (nontuberculous) |
| Pelvic inflammatory disease (STD) |
| **Psittacosis (Category B)** |
| **Q Fever (Category B)** |
| Reye syndrome |
| Rheumatic fever (newly diagnosed and meeting the Jones criteria) |
| Rocky Mountain spotted fever |
| **Salmonellosis (Category B)** |
| Shigellosis |
| Streptococcal disease (all invasive disease caused by Groups A and B Streptococci) |
| Streptococcus pneumoniae invasive disease (invasive pneumococcal) |
| Syphilis (STD) |
| Tetanus |
| Toxic shock syndrome |
| Toxic substance related diseases: Infant methemoglobinemia |
| Toxic substance related diseases: Lead intoxication (specify Pb levels) |
| Toxic substance related diseases: Other metal and pesticide poisonings |
| Toxoplasmosis |
| Trichinosis |
| Typhoid fever |
| **Typhus fever (Category B)** |
| Varicella (chicken pox) – report by number of cases only |
| Yersiniosis |
| Suspected outbreaks of other acute or occupationally–related Diseases |

| **Category III Diseases, which are to be reported to the state epidemiologist within 72 hours** |
|---|
| Acquired Immune Deficiency Syndrome |
| Human Immunodeficiency Virus (HIV) Infection |
| CD$+ T-lymphocyte ,200/ul or CD4+ T-lymphocyte percentage of total lymphocytes <14 |

**Att Op 1B: CDC Category A, B and C Diseases**

## Category "A" Diseases

The U.S. public health system and primary healthcare providers must be prepared to address various biological agents, including pathogens that are rarely seen in the United States. High-priority agents include organisms that pose a risk to national security because they

- can be easily disseminated or transmitted from person to person;
- result in high mortality rates and have the potential for major public health impact;
- might cause public panic and social disruption; and
- require special action for public health preparedness.

1. Anthrax (Bacillus anthracis)
2. Botulism (Clostridium botulinum toxin)
3. Plague (Yersinia pestis)
4. Smallpox (variola major)
5. Tularemia (Francisella tularensis)
6. Viral hemorrhagic fevers (filoviruses [e.g., Ebola, Marburg] and arenaviruses [e.g., Lassa, Machupo])

## Category "B" Diseases

Second highest priority agents include those that

- are moderately easy to disseminate;
- result in moderate morbidity rates and low mortality rates; and
- require specific enhancements of CDC's diagnostic capacity and enhanced disease surveillance.

1. Brucellosis (Brucella species)
2. Epsilon toxin of Clostridium perfringens
3. Food safety threats (e.g., Salmonella species, Escherichia coli O157:H7, Shigella)
4. Glanders (Burkholderia mallei)
5. Melioidosis (Burkholderia pseudomallei)
6. Psittacosis (Chlamydia psittaci)
7. Q fever (Coxiella burnetii)
8. Ricin toxin from Ricinus communis (castor beans)
9. Staphylococcal enterotoxin B
10. Typhus fever (Rickettsia prowazekii)
11. Viral encephalitis (alphaviruses [e.g., Venezuelan equine encephalitis, eastern equine encephalitis, western equine encephalitis])
12. Water safety threats (e.g., Vibrio cholerae, Cryptosporidium parvum)

## Category "C" Diseases

Third highest priority agents include emerging pathogens that could be engineered for mass dissemination in the future because of

- availability;
- ease of production and dissemination; and
- potential for high morbidity and mortality rates and major health impact

These diseases include emerging infectious diseases such as Nipah virus.

## Att-Op-3A: Incident Command System

A. Communities will establish a mechanism for establishing an Emergency Operating Center (EOC) for events that could impact the public health of the community. An EOC would be established upon the recommendation of Public health officials when the health of the community is at risk. It may contain decision makers from Health, Law Enforcement, Emergency Medical Services, and City/County Administration. It is preferable that liaisons to the EOC have a working knowledge of the Incident Command System, have accountability for the agencies that they represent, and leadership skills to deal with complex issues.

B. Communities will establish an Incident Command Structure to guide the community through large-scale events that require varied resources from public health, health, law enforcement, emergency medical services, fire, emergency management, and local government and collaboration with state and federal agencies. See Attachments: Biological Event Phases I and II.

C. The following is a model for a community EOC and Unified Incident Command Structure developed by a multidisciplinary group in Eau Claire County. It is meant to direct local control for 72 hours following an event.

1. EOC: The EOC consists of representation from the following and may vary depending on the nature and scope of the incident. (The model used is assuming a bioterrorism event has occurred involving a Category A Disease).

    a. Health (health department official and health care administrative representative)
    b. Emergency Management
    c. Law Enforcement
    d. Fire/Emergency Medical Services
    e. City Official
    f. County Official

2. Public Information Officer: responsible for information released to the media and the public.

3. Liaison Officer: responsible for coordinating interaction with state and federal agencies with jurisdiction over the incident.

4. Unified Incident Command: includes representation from all entities required for operational decision making regarding the incident

5. Safety Officer: responsible for overseeing safety of the community and all participants in the plan.

6. Branches include: Health, Law Enforcement, Fire/EMS, Planning, Logistics, and Finance

   a. Health Branch – Under the direction of the EOC, the Health Branch coordinates necessary health-related services in response to a biological agent event. Services are provided by hospitals, clinics, public health, mental health providers, pharmacies and laboratories. The Health Branch provides for 2-way communication of needs and planned responses between health care providers and incident command.

   b. Mobilization and Resource Coordination – Mobilizes health care organizations to implement response plans to the biological agent event. Communicates needs for resources including supplies, equipment, and personnel. Coordinates resource utilization by health care organizations responding to the event.

      1) Internal Plans Implementation – Assures that appropriate health organization in the community initiate their biological agent response plans.

      2) Staging – Identifies and communicates the need for facilities to shelter people in need of medical care (including mortuary care) until health care facilities are identified and prepared. Identifies and communicates the need for areas where resources, such as personnel, equipment and supplies may be kept while awaiting assignment.

      3) Personal Protective Equipment (PPE) – Identifies and communicates health care providers' needs for PPE such as masks, gloves, etc. Includes equipment for patient decontamination, if needed.

      4) Infrastructure Equipment and Space – Assesses health care providers' needs and resources with regard to bed capacity and other space needs and for medical equipment such as ventilators, portable hepafilters, etc.

      5) Staffing – Identifies needs for health care personnel to respond to the biological agent event. Includes identifying vaccinated/prophylaxed staff as needed. Assures credentialing protocols are followed. Coordinates assignment of qualified staff.

      6) Regional Health Care Facility Notification – Alerts surrounding Western Wisconsin health care facilities of the occurrence of a

biological agent event. Identifies and communicates unmet needs that are beyond the capacity of Eau Claire County health care facilities, seeking assistance from other facilities in the region.

c. Prevention and Treatment – Facilitates and coordinates infectious disease prevention and treatment interventions by health care providers in response to a biological agent event.

1) Vaccination – Facilitates and coordinates vaccine administration when indicated to protect health care providers, first responders and the general public from the infectious disease caused by the biological agent. Identifies and communicates needs for resources such as clinic sites, supplies, pharmaceuticals, educational materials and security personnel as well needs for assistance in notifying those in need of vaccination.

2) Prophylactic Treatment – Conducts and coordinates epidemiologic investigation and follow-up in response to a biological agent event. Identifies persons exposed to the agent and assures that they receive education and timely prophylactic treatment. Facilitates mass public prophylaxis when indicated. Communicates the need for resources including supplies, pharmaceuticals, personnel, and educational materials.

3) Medical Treatment – Coordinates provision of medical care to suspect and confirmed cases in a biological agent event. Identifies and communicates the needs for supplies, equipment and personnel. Communicates the need for alternative care sites when demand exceeds the available capacity of local providers.

4) Isolation – Assures that appropriate measures are initiated to control communicable disease transmission through isolation of infected persons, including in-home and in-facility isolation. Communicates the need for support such as training, personnel, and educational materials. Communicates the need for alternative isolation facilities when the demand for inpatient isolation exceeds the capacity of local health care facilities.

5) Epidemiology – Investigates and documents the frequency and distribution of the biological agent disease in the population. Studies the interrelationships of factors contributing to disease incidence. Applies this knowledge to control disease spread in the community.

6) Hazard Assessment – Assesses and reports the occurrence and distribution of actual and potential hazards in the community related to the response to the biological agent event.

7) Environmental Control Measures – Recommends interventions and communicates the need for resources to mitigate environmental hazards and prevent additional disease and/or injury.

d. Community Information – Develops and disseminates information to healthcare providers and the public about the biological agent and health-related recommendations.

1) Treatment Guidelines – Develops and disseminates to health care providers standardized treatment guidelines that are based upon the most current DPH/CDC recommendations.

2) Community Information – Develops and disseminates information to the public on topics pertinent to the biological agent event such as:
   - Disease information
   - Personal protective measures
   - Treatment locations and instructions about how to access care
   - Mental health resources

3) Healthcare Guidelines – Develops and disseminates information regarding health and safety measures for health care providers and emergency responders.

e. Surveillance – On an ongoing basis, collects, analyzes, and interprets health data essential to the planning, implementation, and evaluation of the response to a biological agent event.

1) Data Collection and Analysis – Collects, analyzes and reports pertinent data to the EOC and unified command.

2) Disease Monitoring – Evaluates the performance of the biological event response in controlling biological agent transmission. Identifies concerns and makes recommendations to improve the effectiveness of disease control measures. Prepares regular reports on the status of the outbreak to the EOC to communicate to the public.

3) Environmental Health Monitoring – Monitors the environment to identify other health hazards associated with the biological agent event and recommends measures to mitigate these hazards.

e. Law Enforcement: Includes city, county and state law enforcement agencies and may include campus and facility security and FBI

- Site security
  - Evacuation
  - Perimeter security
  - E.O.C. security
  - Egress/Ingress control

- Patrol
  - Evacuation
  - Traffic control
  - Incident response
  - Community Security

- Investigation
  - Evidence gathering/processing
  - Liaison with state/federal
  - Intelligence gathering
  - Surveillance
  - Search warrants
  - Wire taps

- Communication

- Immediate dispatch
- Local notifications
- Activate E. B. S.
- Prioritize/disseminate needed information

f. Fire/EMS: Includes local and area fire departments and EMS responders

- EMS
  - Communications
  - Triage
  - Treatment
  - Transport
  - Transfers

- HAZMAT
  - Research
  - Entry
  - Decon
  - Medical
  - Monitor
  - Safety

- Suppression
  - City Operations
  - EMS Assist
  - Logistical Support
  - Mutual Aid

- Support
  - Vehicles
  - Fuel
  - Food
  - Personnel
  - Equipment
  - Supplies

g. Planning: Includes representation from Health (Mental health and public health), Fire/EMS, Law Enforcement, and Support services.

- Communications
- Research
- Legal
- Human Resources
- Recovery

h. Logistics

- Communications
  - Two-way radio
  - Cell phones
  - Land lines
  - Pagers
  - Phone lists
  - Fax's
  - Email/Lan/Wan
  - Technical support
  - Courier services

- Health
  - NPS
  - Health care credentialing
  - Lab services
  - Medical supplies
  - Pharmaceuticals
  - Management
  - Mutual aid
  - Mental health
  - Interpreters
  - Clergy

- Food
  - Mass kitchens
  - Meals (MRE)
  - Lab services
  - Volunteers
  - Food supplies
  - Food distribution

- Supply
  - Generators'
  - Printing
  - Heating
  - Refrigeration
  - Clothing (PPE)
  - Blankets
  - Cots
  - Office supplies
  - Fuel

- Facilities
  - Medical
  - Mass Care
  - Isolation
  - Quarantine
  - Shelters
  - Distribution Center
  - Staff housing
  - Mortuaries
  - Food services

- Transportation
  - Mass transit
  - NPS transportation
  - Specimen
  - General
  - Heavy equipment
  - Specialty
  - Refrigeration
  - Semi

i. Finance and Record Keeping

- Finance
  - Profice codes
  - Documentation (pictures)
  - Declaration of an emergency
  - Narratives of Responders
  - State/federal notification

- Liaison with Private Citizens
  - FEMA/State reimbursement
  - Aid to infrastructure
  - Percent of insurance coverage
  - Victim Tracking

- Termination
  - Emergency Management Liaison
    - County
    - City
    - State
    - School district
    - University/colleges
    - Red Cross
    - Health

## Att-Op-4A: Clinical Syndromes, Infectious Agents & Precautions

| Clinical Syndrome/Condition | Select Potential Infectious Agents | Precautions to Use Empirically |
|---|---|---|
| **Diarrhea** | | |
| Acute diarrhea with a likely infectious cause in an incontinent or diapered patient. | Enteric pathogens and food/water safety threats such as *Salmonella* species, *E. coli* 0157:H7, *Shigella*, hepatitis A, rotavirus, *Vibrio cholerae*, *Cryptosproidium*. | Contact |
| **Hemorrhage/Fever** | | |
| Marked fever, fatigue, dizziness, bleeding under skin, internal organs, or body orifices. | Viral hemorrhagic fevers | Airborne Contact* |
| **Meningitis** | | |
| Headache, vomiting, stiff neck. | *Nisei meningitidis* | Droplet |
| **Rash illnesses** | | |
| Petechial/ecchymotic with fever. | *Neisseria meningitidis* | Droplet |
| Vesicular or vesicular/pustular pox. | *Varicella*, smallpox*, monkeypox viruses | Airborne Contact |
| **Skin or Wound Infection** | | |
| Abscess or draining wound that cannot be covered. | *Staphylococcus aureus*, group A streptococcus | Contact |

***Also requires eye protection for all patient contact.**



Version: 3
Date: 8-27-2004

## Att-Op-4A: Clinical Syndromes, Infectious Agents & Precautions

| Clinical Syndrome/Condition | Select Potential Infectious Agents | Precautions to Use Empirically |
|---|---|---|
| **Respiratory illness** | | |
| Cough/night sweats/fever, abnormal chest x-ray, esp. cavitation, infiltrate or fibrotic changes, or high-risk patient (*foreign born, homeless, drug user, HIV+ or unknown status, previous TB or recently exposed to TB, congregate living, etc.).* | *Mycobacterium tuberculosis* | Airborne |
| Paroxysmal or severe persistent cough during periods of pertussis activity. | *Bordetella pertussis* | |
| Fever, headache, weakness, rapidly developing pneumonia. | *Yersinia pestis* (pneumonic plague) | |
| Atypical pneumonia of unknown etiology in healthcare workers, travelers to former SARS endemic areas, close contacts of persons with atypical pneumonia when SARS cases are NOT occurring in world. | SARS coronavirus | Droplet |
| Fever and mild to severe respiratory symptoms in persons who traveled to SARS endemic areas within 10 days of symptom onset or are close contacts of suspect SARS cases. | SARS coronavirus | Airborne Contact* |
| Respiratory infections, particularly bronchiolitis and croup, in infants and young children. | Respiratory syncytial or parainfluenza virus | Contact |

***Also requires eye protection for all patient contact.**

# Att-Op-4B: Guidelines for Patient Management

**Standard Precautions:** 1) Prevent direct contact with all body fluids & blood, secretions, excretions, non-intact skin, rashes or mucous membranes. 2) Routine practices include: The wearing of gowns, gloves and mask/eye protection/face shield while performing procedures that cause splash/spray. **Contact Precautions:** Hand washing after each patient encounter.

* Contact precautions needed only if the patient has skin involvement (bubonic plague: draining bubo) or until decontamination of skin is complete (T2 Mycotoxins).
# A surgical mask and eye protection should be worn if you come within 3 feet of the patient. Airborne precautions are needed if patient has cough, vomiting, diarrhea or hemorrhage.
% Contact precautions needed only if the patient is diapered or incontinent.

| **Patient Management** | **BACTERIAL AGENTS** | Anthrax | Brucellosis | Cholera | Glanders | Bubonic Plague | Pneumonic Plague | Tularemia | Q Fever | **VIRUS** | Smallpox | Venez. Equine Encephalitis | Viral Encephalitis | Viral Hemor. Fever | **BIOLOGICAL TOXINS** | Botulism | Ricin | T-2 Mycotoxins | Staph. Enterotoxin B |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Isolation Precautions** | | | | | | | | | | | | | | | | | | | |
| Standard Precautions | | X | X | X | X | X | X | X | X | | X | X | X | X | | X | X | X | X |
| Contact Precautions | | | | X# | X* | X* | | | | | X | | | X | | | | X* | |
| Airborne Precautions (Neg. Press. Rm and N 95 mask for all entering the room) | | | | | | | | | | | X | | | X% | | | | | |
| Droplet Precautions (surgical mask) | | | | | | | X | | | | | | | X% | | | | | |
| **Patient Placement** | | | | | | | | | | | | | | | | | | | |
| No restrictions | | X | X | X | X | X | | X | X | | | X | X | | | X | X | X | X |
| 'Like' patients in the same room | | | | X# | X* | X* | X | | | | X | | | X | | | | X* | |
| Private Rm | | | | X# | X* | X* | X | | | | X | | | X | | | | X* | |
| Neg. Press. Rm | | | | | | | | | | | X | | | X% | | | | | |
| Door closed at all times | | | | | | | | | | | X | | | X% | | | | | |



Version: 3
Date: 8-27-2004

## Att-Op-4B: Guidelines for Patient Management

| Patient Management | BACTERIAL AGENTS | Anthrax | Brucellosis | Cholera | Glanders | Bubonic Plague | Pneumonic Plague | Tularemia | Q Fever | VIRUS | Smallpox | Venez. Equine Encephalitis | Viral Encephalitis | Viral Hemor. Fever | BIOLOGICAL TOXINS | Botulism | Ricin | T-2 Mycotoxins | Staph. Enterotoxin B |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Patient Transport** | | | | | | | | | | | | | | | | | | | |
| No restrictions | | X | X | X | X | X | | X | X | | | X | X | | | X | X | X | X |
| Movement for med. treatment only | | | | X# | X* | X* | X | | | | X | | | X | | | | X* | |
| Mask the patient | | | | | | | X | | | | X | | | X% | | | | | |
| **Cleaning, Disinfection** | | | | | | | | | | | | | | | | | | | |
| Routine terminal room cleaning with hosp. apprv. disinfectant | | X | X | X | X | X | X | X | X | | X | X | X | | | X | X | X | X |
| Disinfect surfaces with 10% bleach solution or phenolic disinfectant | | | | | | | | | | | | | | X | | | | | |
| Dedicated equipment (before depart Rm.) | | | | X# | X* | X* | | | | | X | | | X | | | | X* | |
| Linen management as with all other patients | | X | X | X | X | X | X | X | X | | | X | X | X | | X | X | X | X |
| Linens autoclaved before laundering in hot water with bleach added | | | | | | | | | | | X | | | | | | | | |

## Att-Op-4B: Guidelines for Patient Management

| Patient Management | BACTERIAL AGENTS | Anthrax | Brucellosis | Cholera | Glanders | Bubonic Plague | Pneumonic Plague | Tularemia | Q Fever | VIRUS | Smallpox | Venez. Equine Encephalitis | Viral Encephalitis | Viral Hemor. Fever | BIOLOGICAL TOXINS | Botulism | Ricin | T-2 Mycotoxins | Staph. Enterotoxin B |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Post-mortem Care** | | | | | | | | | | | | | | | | | | | |
| Standard Precautions | | X | X | X | X | X | X | X | X | | X | X | X | X | | X | X | X | X |
| Droplet Precautions (surgical mask) | | | | | | | X | | | | | | | | | | | | |
| Contact Precautions | | | | | X* | X* | | | | | X | | | X | | | | X* | |
| Avoid autopsy or use Airborne Precautions & HEPA filter | | | | | | | X | | | | X | | | X% | | | | | |
| Routine terminal room cleaning with hosp. apprv. disinfectant | | X | X | X | X | X | X | X | X | | X | X | X | | | X | X | X | X |
| Disinfect surfaces with 10% bleach solution or phenolic disinfectant | | | | | | | | | | | | | | X | | | | | |
| Minimal handling of body; seal body in leak-proof material | | | | | | | | | | | | | | X | | | | | |
| Cremate body whenever possible | | | | | | | | | | | X | | | | | | | | |
| **Discontinuation of Isolation** | | | | | | | | | | | | | | | | | | | |
| 48 hrs of antibiotic & clinical improvement | | | | | | | X | | | | | | | | | | | | |
| Until all scabs separate | | | | | | | | | | | X | | | | | | | | |
| Until skin decontamination completed (1 hr contact time) | | | | | | | | | | | | | | | | | | X | |
| During the illness | | | | X# | X* | X* | | | | | | | | X | | | | | |

## Att-Op-4B: Guidelines for Patient Management

| Waste Disposal Methods | | |
|---|---|---|
| | Routine Disposal of Infectious Waste | Use of Biohazard Bags for all PPE, Deposable Patient Care Items & Equipment |
| **Category A** | | |
| Anthrax | **X** | |
| Brucellosis | **X** | |
| Glanders | **X** | |
| Bubonic Plague | **X** | |
| Pneumonic Plague | **X** | |
| Tularemia | **X** | |
| Q Fever | **X** | |
| **Viruses** | | |
| Orthopox viruses (smallpox / monkeypox | | **X** |
| Venesqualan Encephelitis | **X** | |
| SARS | **X** | |
| Viral Hemorrhag Fever | **X** | |
| **Toxins** | | |
| Botulism | **X** | |
| Ricin | **X** | |
| T-2 Mycotoxin | **X** | |
| Staph. (SEB) | **X** | |

# Att-Op-4C: Infection Control & Isolation of a Suspected Case of Smallpox

## I. Introduction

These protocols focus on the management of a suspected case of smallpox, occurring in the absence of an already recognized outbreak, that is, a case that may represent the index case of a bioterrorist event.

The primary purpose of airborne and contact precautions is to confine and contain the infectious agent to the greatest degree possible while continuing to meet the needs of the patient and simultaneously minimizing the risk of contagion to others.

**Definitions:**

A **"case"** means a person determined to have a particular communicable disease on the basis of clinical or laboratory criteria or both. HFS145.03 (2)

A **"suspected case"** means a person thought to have a particular communicable disease on the basis of clinical or laboratory testing. HFS145.03 (27)

**"Close contacts"** are defined as persons, who were in close proximity to the suspected case. All persons in the same room (*i.e., waiting room)* as the suspected case should be considered "close contacts".

**"Isolation rooms"** are defined as negative air pressure airborne isolation rooms (hereinafter, "NPAir") with a minimum of 6-12 air exchanges per hour and direct exhaust to the outside, which is located more than 25 feet from an air intake and from areas where people may pass. If air cannot be exhausted directly to the outside more than 25 feet from an air intake and from areas where people may pass, then air should be filtered through an appropriately installed and maintained HEPA filter. These rooms should be tested monthly (and daily when in use) to verify negative airflow.

Note: If rooms in older facilities must be "switched on" to provide 6- 12 air exchanges per hour, then a method must be implemented to ensure that this occurs an is monitored.

**"Preidentified room":** In hospitals that do not have "NPAir" that meet the above criteria, an enclosed private room(s) should be preidentified for "isolating" patients with fever and rash illnesses to minimize exposure to other patients and staff (*e.g., an examination room at the end of a hallway).* A transportation route from the Emergency Department to this preidentified room also is to be established.

**"Vaccine eligible" (see** Appendix I**)**

## II. Initial Evaluation of Suspected Case

A. Any patient, presenting for evaluation in the Emergency Department with fever and an acute, generalized vesicular or pustular rash will be immediately identified, masked and placed in "NPAir".

B. Recognition of a Suspected Case

1. Reception staff and all medical care staff are to be trained to be on alert for patients with any rash illnesses and will immediately place the suspected case in a "NPAir" or a pre-identified room, when no "NPAir" is available.

   a. The poster, "Evaluating Patients for Smallpox - Acute, Generalized Vesicular and Pustular Rash Illness Protocol", should be available at the reception/registration desk.

      Note: The poster can be found at
      http://www.bt.cdc.gov/agent/smallpox/diagnosis/evalposter.asp

2. Once a suspected case has been placed in "NPAir", the following steps are to be implemented:

   a. Signage is placed at the entrance of the Emergency Department, stating that any patient with fever and rash immediately notify reception staff.

   b. All ambulance and pre-hospital support staff are to pre-notify the Emergency Department, if transporting patient with fever and rash illnesses.

C. Isolation of Suspected Case

1. A surgical mask is to be placed immediately on patients, presenting with fever and rash illnesses

2. Airborne and Contact Precautions are to be employed.

## Att-Op-4C: Infection Control & Isolation of a Suspected Case of Smallpox

D. Clinical Assessment of the Risk of Smallpox

1. The clinical assessment of smallpox will follow the CDC criteria for determining whether the suspected case is at low, moderate or high risk for smallpox (**see Appendix II**)

   a. For **low risk patients**, as defined in **Appendix II** (especially if chickenpox or disseminated herpes zoster is the likely diagnosis, based on history and physical examination), varicella laboratory testing is optional and the patient is to be kept isolated, using airborne and contact precautions, as per the hospital's varicella protocol.

      Transfer of Specimens either to a laboratory within the facility or to an outside laboratory are to follow the guidelines of the Wisconsin State Laboratory of Hygiene.

      Note: The protocols for the transfer of specimens can be found at:
      http://www.iata.org/dangerousgoods/index
      http://hazmat.dot.gov/rules.htm

      For patients determined to be at low risk for smallpox, but for whom the diagnosis is uncertain, laboratory testing for varicella zoster virus antigen (using rapid DFA or PCR antigen tests) and/or other conditions should be considered as indicated clinically.

      **If rapid varicella antigen testing or a consultation is needed, the local health department in the county/city, in which the hospital is located, is to be contacted.**

   b. For moderate risk patients, as defined in **Appendix II**, **The local health department in the county/city, in which the hospital is located, is to be contacted immediately.** The local health department will respond to the hospital request for assistance by providing case interview, contact tracing and public health consultation on management of the patient and all hospital "close contacts". In addition, **an infectious disease or dermatology consult is to be sought** as well as rapid testing for varicella (DFA or PCR testing for varicella antigen) if available, and for other diseases as clinically indicated.

      If specialty consultation and/or rapid testing is not available, or the diagnosis remains uncertain, the local health department will assist in determining the likelihood of smallpox and arrange for rapid diagnostic

testing for varicella (to help differentiate chickenpox from smallpox) and/or variola, if indicated.

Specialty consultation, if not locally available, is available through the Wisconsin Division of Public Health, Bureau of Communicable Disease:

1) Business Hours: 608-267-9003 (Note: Request to speak with the Epidemiologist "on call".

2) Outside Business Hours: 608-258-0099 (Note: This telephone number is for health professionals only and should not be made available to the public.)

c. For **high-risk patients**, as defined in **Appendix II, the local health department in the county/city, in which the hospital is located, is to be contacted immediately.** The local health department will respond to the hospital request for assistance by providing case interview, contact tracing and public health consultation on management of the patient and all hospital personnel. In addition**, an infectious disease or dermatology consult is to be sought**.

## III. Management of the Suspected Case, Pending Laboratory Test Results for Smallpox

Hospitals will take the following steps for managing suspect **moderate** or **high-risk** patients to protect other patients, staff and visitors from smallpox infection, while awaiting the arrival of the local health department.

A. The suspected case is to remain isolated on airborne and contact precautions in the Emergency Department. If the local health department staff agree that the suspected case is at **moderate** or **high risk** for smallpox and that variola testing is indicated, the suspected case will be admitted and moved to a "NPAir" or held in the pre-identified room, until transferred to another facility with "NPAir."

It is recommended that the inpatient NPAir have a toilet and sink and a bath or shower

B. Once the hospital has utilized all its "NPAir" for suspected cases, it is to transfer other suspected cases in need of admission to another facility with "NPAir".

C. Infection control personnel and the on-call hospital administrative staff are to be immediately notified regarding the suspected case. If not already involved, consultations are to be requested from dermatology and/or infectious disease specialists.

D. Isolation signs, noting the need for airborne and contact precautions, are to be displayed outside the suspected case room and the door to the suspected case room is to be kept closed (self-closing doors are preferable).

E. All personal protective equipment (*e.g., gowns, eye protection, gloves, and fit-tested N95 or higher respirators)* is to be stocked outside the door to the suspected case room. Hand hygiene products, such as disinfectant gels, are to be available for use by all staff and visitors outside the door to the suspected case room.

1. Eye protection is to be worn when within 3 (three) feet of the coughing suspected case. (*Note: Eye protection should be such that it protects the eyes from splashes from above or from the sides of the eye protection.)*

2. If available, the suspected case is to be placed in "NPAir" with an anteroom that has a sink, so that persons leaving the room can dispose of their protective clothing and equipment and wash their hands before exiting to the hallway.

3. In the absence of an anteroom, gowns, gloves and shoe covers are to be removed inside the suspected case room and discarded in a waste receptacle just inside the room by the door. A separate waste receptacle is to be placed immediately outside the suspected case room for disposal of used respirators.

F. The number of persons, who enter the suspected case room, is to be minimized as much as possible. Visitors are to be limited to:

1. Designated public health and law enforcement investigators and

2. Immediate family members, designated by the local health department in collaboration with hospital staff, who have already had "close contact" with the suspected case after the onset of his/her rash and prior to hospitalization.

3. All staff and designated family members, prior to entering the room, are to be instructed in the meaning of contact, airborne and standard precautions.

a. All hospital staff (*including transport personnel)* and visitors must don contact and airborne personal protection and eye protection, if within 3 (three) feet of a coughing suspected case *(i.e., disposable gloves, eye protection, gowns, and an N-95 or higher respirator)* regardless of their prior smallpox vaccination status.

b. Non-healthcare individuals, entering the room, must have assistance in selecting appropriate personal protective equipment.

c. All hospital, public health and law enforcement staff will have undergone fit-testing for appropriate respiratory protection.

d. As per standard precautions, eye protection or a face shield to protect mucous membranes of the eyes are to be worn for all procedures or patient care activities that are likely to generate splashes or sprays of blood, body fluids, secretions or excretions (*e.g., respiratory suctioning).*

e. Preferably, only persons, who are "vaccine eligible are to be allowed in the suspected case room.

f. A staff person is to be stationed outside the suspected case room at all times to ensure adherence to all the above protocols.

g. Information on all persons, who enter the room, is to be kept in a logbook outside the suspected case's room.

1) Specifically, the names and job duty (*for hospital staff)* are to be recorded. Non-hospital staff and visitors are to provide names, work location, work phone number, home phone number, cellular phone number, and beeper numbers on the logbook. (See **Appendix III)**.

2) **Appendix III** is to be used for tracking all "close contacts". This information will be used by the local health department to ensure that all persons, who have had "close contact" with the suspected case, are prioritized for immediate vaccination in the event that smallpox is confirmed.

h. Any non-vaccinated person, entering the suspected case room, will be vaccinated as soon as the suspected case is confirmed. If the suspected case cannot be confirmed within three days, all persons in "close contact" with the suspected case will be vaccinated.

G. The hospital is to ensure that the following additional infection control precautions are adhered to:

1. Disposable items are to be used whenever possible.

2. After use, all disposable personal protective equipment is to be placed into a plastic biohazard bag and left in the suspected case room (*gowns, shoe covers, gloves)* or outside of the room (*respirators).* Ideally, these are to be placed in the anteroom, if a NPAir with anteroom is available. N-95 respirators should not be re-used; if positive air pressure respirators (PAPR) are used, the PAPR should be cleaned and disinfected prior to entering another patient's room.

3. As much as possible, dedicated patient care equipment (*e.g., blood pressure cuffs and stethoscopes)* is to be used for care of the suspected case and left in the patient's room. If equipment must be used on other patients (*e.g., portable X-ray machine),* all equipment must be cleaned and disinfected with EPA-registered hospital disinfectants (*e.g., quaternary ammonium compounds)* or sodium hypochlorite (*1:10 dilution of household bleach).*

    a. The Medical Record is to be kept outside the room of the suspected case so as to prevent contamination of the Medical Record.

    b. All non-essential equipment and supplies are to be removed from the room of the suspected case before the suspected case is admitted to the room.

    c. Staff and others entering the room of the suspected case should keep any equipment and supplies (*e.g. phlebotomy*) to the minimum necessary.

4. All non-sharps waste is to be disposed in impervious biohazard bags of adequate strength; otherwise, they are to be placed in a second biohazard bag for disposal or transported for incineration or for other approved disposal methods. Since the laboratory test results for a **moderate** to **high risk** patient should be available within 24-48 hours after specimens are collected, hospitals, if possible, are to keep all biohazard waste bags in the suspected case room until smallpox has been ruled out. If smallpox is ruled out, waste can be disposed of according to standard waste disposal protocols.

   If smallpox is confirmed, this waste is to be incinerated.

5. Disposable trays and utensils should be used. All food scraps should be bagged and kept in the suspected case room while awaiting confirmation. This waste is then to be disposed of in the same manner as mentioned in # 4 above (incinerated if smallpox is confirmed; ordinary disposal is smallpox is ruled out).

6. All used laundry and linens are to be handled carefully to prevent aerosolization or direct contact with potentially infectious material. Anyone directly handling the suspected case's linen or laundry is to wear a gown, gloves and a respirator (N-95 or higher). Laundry and linens are to placed in biohazard bags of adequate strength; otherwise, they are to be double-bagged and are to remain in the room in a covered hamper until laboratory results are available.

H. The suspected case is to be kept in his/her room except for medically essential procedures that cannot be done at the bedside.

   1. Any movement of the suspected case outside of the room of the suspected case should only be done in consultation with Infection Control staff.

   2. If the suspected case needs to be transported, the security of the suspected case room must be maintained.

3. To minimize the potential for contamination when transported outside of the "NPAir", a surgical mask is to be placed on the suspected case. Active skin lesions must be completely covered. A sheet is to be used to cover their skin as much as possible; the linens are be tucked under the stretcher to manipulation of the linens to protect against aerosolization of any potentially infectious material. All staff are to wear a gown, gloves and a respirator *(fit-tested N-95 or higher*) even when the suspected case is covered and wearing the surgical mask.

4. If staff involved in transporting the suspected case have direct contact with the suspected case (*e.g., contact with skin or oral secretions*) when moving the suspected case from his/her bed to the stretcher or wheel chair, their gowns and gloves may be contaminated.

    a. Prior to leaving the suspected case's room, staff are to remove their personal protective equipment and don clean protective gear.

    b. Unnecessary equipment in the room should be removed or protected from inadvertent contamination (e.g. covered with a plastic sheet or drape).

    c. The department receiving the patient for the medical procedure (*e.g., radiology or surgery*) are to be notified prior to transport so that appropriate arrangements can be made for direct and immediate access to the procedure room.

    d. The infection control precautions outlined above are to be followed by all hospital staff involved in the care of the suspected case while he/she is undergoing medical procedures outside of the negative pressure airborne isolation room.

    e. Transport equipment *(e.g., stretcher or wheelchair)* or equipment in the procedure room (*e.g., x-ray table)* is to be cleaned with EPA-registered hospital disinfectants (*e.g., quaternary ammonium compounds)* or sodium hypochlorite (*1:10 dilution of household bleach).*

f. All waste, linens, etc. from the suspected case is to be placed in biohazard bags of adequate strength; otherwise, they are to be double-bagged and stored in the suspected case room. Sharps, used on the suspected case, are to be placed in the sharps container, which is to be placed in biohazard bags of adequate strength; otherwise, they are to be double-bagged and stored in the suspected case room

g. The logbook is to accompany the suspected case and all staff, who have contact with the suspected case, should complete the information in the logbook. Care is to be taken not to contaminate the logbook.

h. All non-vaccinated staff, who participate in any procedure that takes place outside the suspected case room, are to be vaccinated as soon as the suspected case is confirmed or if the case is still in doubt after three days.

J. Care is to be taken when handling routine clinical laboratory specimens. Laboratory requests are to be limited to those tests that are essential to patient management. All clinical specimens are to be placed in double, zip-locked bags that are tightly sealed and properly labeled prior to transport to the laboratory.

1. Specimens are to be hand-carried to the laboratory and pneumatic tube systems are not to be used.

2. Laboratorians are to be trained in handling clinical specimens and understand that the risk of smallpox infection due to contact with samples for a suspect case is low when handled appropriately.

   NOTE: An exception will be laboratory tests involving the skin lesions themselves (*e.g., DFA testing for varicella)* where ideally only pre-vaccinated laboratory staff are to be handling the specimens).

3. Non-vaccinated laboratory staff are to be vaccinated if they have handled the suspected case specimens and if the suspected case is confirmed or if the suspected case is still in doubt after three says.

## III. Management of the Emergency Department or Clinical area, Pending Evaluation and Laboratory Test Results:

## Att-Op-4C: Infection Control & Isolation of a Suspected Case of Smallpox

The following guidelines apply to the Emergency Department or clinical area where the **moderate** or **high-risk** patient was initially evaluated and may have spent time prior to being placed in a negative pressure airborne isolation room.

No additional steps are needed for management of the Emergency Department or clinical area, if the patient is deemed to be at **low risk** for smallpox, unless indicated based on the patient's diagnosis (*e.g., measles*)

After notification of the local health department regarding a **moderate** or **high risk** patient and the local health department concurs that the individual is at **moderate** or **high risk** for smallpox, the following actions will be taken while awaiting arrival of the local health department evaluation and/or laboratory determination of whether or not the suspected case has smallpox:

A. Management of "Close Contacts":

1. All persons, including visitors and other patients (*as long as medically stable),* in the Emergency Department, clinical area or other areas of the hospital who had "close contact" with the suspected **moderate** or **high risk** patient before he/she was placed in a negative pressure airborne isolation room are to be moved to a separate room apart from the Emergency Department or clinical area.

2. These "close contacts" are to be detained in the separate room and their information entered into the log (see **Appendix III**). No "close contact" is permitted to leave the room nor are any other persons to be allowed to enter the room, unless authorized by the hospital or the local health department.

3. Infection control or other appropriate hospital staff are to start a log sheet (see **Appendix III**), tracking all "close contacts" of the suspected **moderate** or **high risk** case prior to his/her being placed in an negative pressure airborne isolation room to share with the local health department staff when they arrive.

    a. The names, home addresses, and 24-hour contact information (*including home and work telephone, cellular phone, and beepers)* are to be noted for all "close contacts".

    b. If the suspected case visited another part of the hospital (*cafeteria*) or was transported to another location during their evaluation (*e.g. radiology*) prior to being placed in a negative pressure airborne isolation room and under airborne and contact precautions, the contact tracking should be

extended to these additional areas. "Close contacts" are to be vaccinated if the case is confirmed or if the case is still in doubt after three days.

4. As it may take time for the local health department to arrive on-site, the hospital staff should pre-designate infection control or other appropriate staff person(s) to begin to counsel these patients and visitors.

    a. Pre-prepared fact sheets for use in educating persons, who were potentially exposed to smallpox, about their risk and what steps the local health department will take in the event that smallpox is confirmed are included in **Appendix IV**; hospitals are to have copies ready to distribute to potential "close contacts" to read while awaiting the arrival of the local health department staff.

5. The local health department is to send staff to interview and counsel all "close contacts" (*including emergency department and clinic staff, other patients, and visitors*), as well as review the educational materials (e.g., see **Appendix IV**) and provide a 24-hour local health department telephone hotline number for all contacts to use if they have additional questions or concerns after leaving the hospital.

    a. Local health department staff will interview all "close contacts" of **moderate** or **high risk** patients and ensure that emergency contact information has been obtained in the event that the suspected case is confirmed as smallpox, so that these persons can be immediately called with instructions on where and when to receive smallpox vaccination.

*6.* Hospital staff are to ensure that all "close contacts" of suspected **moderate** or **high** risk cases remain in the hospital until the local health department staff arrive:

    a. <u>For "close contacts" of **moderate risk** patients**:**</u> If "close contacts" of **moderate risk** patients refuse to wait until the local health department staff arrive, the hospital is to reiterate the importance of staying and if they are unable to convince the person(s) to stay, the hospital must obtain contact information on **Appendix III** *prior* to the "close contact" leaving the hospital.

    b. <u>For "close contacts" of **high risk** patients:</u> If the preliminary assessment by the local health department at the time of the initial telephone consultation is that the suspected case may be at **high risk** for smallpox, the local health department may order the hospital to hold all "close

contacts" in a separate waiting area until local health department staff arrive.

1) The decision to order Emergency Department or clinic "close contacts" to be held will be based on the circumstances of the event.

2) At the time that the decision is made to hold the "close contacts" in the Emergency Department or clinic during the initial telephone consultation, the local health department will fax to the hospital an Order, requiring the holding of the "close contacts", until such time as the local health department staff arrive to interview and counsel these individuals.

3) If the hospital requires assistance to detain these persons, the local health department will contact the law enforcement to advise them of the situation and to request that officers be sent to the hospital to assist in holding the "close contacts".

4) Any patient, who is medically unstable or not able to be moved, is to be cared for in the Emergency Department or clinical area. It is not necessary for the Emergency Department or clinical area staff contacts to be held in this same room as long as these staff are available for interviews when the local health department staff arrive.

B. Cleaning Any Area, Occupied by a Suspected Case

1. Any area, occupied by a suspected case, is to be quarantined until it is cleaned.

2. All equipment and surfaces, including such items as cubicle curtains, carpeting and upholstered items are to be cleaned as per contact isolation protocols with standard EPA-registered hospital disinfectants (*e.g., quaternary ammonium compounds)* or sodium hypochlorite (*1:10 dilution of household bleach)* if smallpox is confirmed or highly suspected.

3. After discussion with the local health department, the Emergency Department or waiting area or other areas, occupied by the suspected case can be re-occupied after

   a. It has been cleaned with EPA-registered hospital disinfectants (*e.g., quaternary ammonium compounds)* or sodium hypochlorite (*1:10 dilution of household bleach)* and

b. An appropriate period of time has elapsed to ensure room clearance, based on the ability of the affected hospital areas' HVAC system to achieve 6 - 12 air exchanges. **Appendix V** should be completed for all rooms and areas in the hospital (*Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care facilities. MMWR 1994; 43 (R-13):page 72).*

c. Facilities engineers are to identify air exchange rates for each room/area in the hospital and use **Appendix V** to post the air exchange rates.

d. Individuals in areas receiving potentially contaminated recirculated Emergency Department air are to be tracked as "close contacts". Once the suspected case is appropriately isolated, an appropriate period of time is to elapse to ensure room clearance, based on 6 - 12 air exchanges in the affected area.

4. The housekeeping staff, involved in cleaning these areas, are to be limited to persons, who are confirmed vaccinated or "preferably vaccine eligible". While cleaning the area, these staff are to use appropriate personal protective equipment (*i.e., disposable gloves, shoe covers and gowns and fit-tested N-95 or higher level of respiratory protection).*

C. Decision Regarding Whether the Emergency Department or Clinical area Should be "Quarantined" or Whether the Hospital Should Consider Temporary "Termination of Services":

1. There is no need to quarantine the hospital, Emergency Department, or clinical area or to consider diversion of patients if

   a. the suspected case was masked when entering the hospital building

   b. the suspected case was admitted directly to a negative pressure airborne isolation room

2. Quarantine of the hospital or any area of the hospital and diversion of patients is to be considered only in consultation with hospital administrative staff, infectious disease and infection control staff and the local health department.

# Att-Op-4D: Infection Control for Suspected Cases of SARS

## I. Introduction

Severe acute respiratory syndrome (SARS) is a new disease that initially emerged in Asia, North America, and Europe in the spring of 2003. SARS appears to be spread primarily by large respiratory droplets during close person-to-person contact. But the possibility of airborne transmission cannot be ruled out, thus infection control measures in health care facilities should include both airborne and contact precautions.

The purpose of airborne and contact precautions is to reduce the risk of transmission of disease while continuing to provide quality patient care.

## II. Definitions

### A. Case Definitions

A **"case"** means a person determined to have a particular communicable disease on the basis of clinical or laboratory criteria or both. HFS145.03 (2)

A **"suspected case"** means a person thought to have a particular communicable disease on the basis of clinical or laboratory testing. HFS145.03 (27)

**See SARS case definitions on page 14.**

### B. Other Definitions

A "**close contact"** is someone who has cared for or lived with a person known to have SARS or has a high likelihood of having direct contact with respiratory secretions and/or body fluids of a patient known to have SARS. Examples of close contact include kissing, embracing, sharing of eating or drinking utensils, close conversation (within 3 feet), physical examination, and any other direct physical contact between persons. Close contact does not include activities such as walking by a person or sitting across a waiting room or office for brief periods of time.

**"Isolation rooms"** are defined as negative air pressure airborne isolation rooms (hereinafter, "NPAir") with a minimum of 6-12 air exchanges per hour and direct exhaust to the outside, which is located more than 25 feet from an air intake and from areas where people may pass. If air cannot be exhausted directly to the outside more than 25 feet from an air intake and from areas where people may pass, then air should be filtered through an appropriately installed and maintained HEPA filter. These rooms should be tested monthly (and daily when in use) to verify negative airflow.

Note: If rooms in older facilities must be "switched on" to provide 6- 12 air exchanges per hour, then a method must be implemented to ensure that this occurs an is monitored.

**"Pre-identified room":** In hospitals that do not have "NPAir" that meet the above criteria, an enclosed private room(s) should be pre-identified for "isolating" patients with fever and respiratory symptoms to minimize exposure to other patients and staff (*e.g., an examination room at the end of a hallway).* A transportation route from the Emergency Department to this preidentified room also is to be established.

## III. Initial Management of Patients with Respiratory Illnesses

Consider placing signs at the entrance of the Emergency Department, instructing persons with respiratory symptoms to immediately notify reception staff. Provide tissues, waste baskets, and alcohol hand gel in waiting areas for use by persons with respiratory symptoms.

Patient transport staff should notify the Emergency Department in advance if transporting patients with fever and respiratory symptoms.

Any patient presenting for evaluation in the Emergency Department with respiratory symptoms will be immediately identified, masked and placed in isolation.

- If no known SARS transmission is occurring in the world, patients will be placed in droplet isolation.
- If SARS cases have been identified anywhere in the world, patients will be placed in an NPAir or pre-identified room.

## Att-Op-4D: Infection Control for Suspected Cases of SARS

**A.** Recognition of a Suspect Case When No SARS Cases are Occurring

**1.** In the absence of SARS cases in the world, screen all hospitalized patients with pneumonia of unknown etiology for the three following characteristics that might indicate a higher index of suspicion for SARS infection:

- In the ten days before illness onset, travel to a previously affected SARS area or close contact with other ill persons who recently traveled to a previously affected SARS area.
- Employment as a health care worker with direct patient contact.
- Close contact with someone recently found to have radiographic evidence of pneumonia of unknown etiology.

**2.** If any one of the above conditions exits, place the patient in standard and droplet precautions and contact the local health department.

**3.** Infection control practitioners and other appropriate health care personnel should be on the alert for cases of unexplained pneumonia among two or more health care workers who work in the same facility. Report such cases to the local health department.

**B.** Recognition of a Suspect Cases When SARS is Occurring

**1.** Once SARS cases have been identified anywhere in the world, all patients with respiratory symptoms who are seen in the health care facility should be screened for risk of SARS using the SARS Assessment Tool (see appendix).

**2.** Place patients in the appropriate isolation precautions based on the outcome of the assessment tool.

**C.** Clinical Assessment of Patients

The following is a summary of assessment steps. Refer to the CDC website at http://www.cdc.gov/ncidod/sars/pdf/smp_supplementd.pdf for more details.

Clinical assessment of patients with respiratory illnesses will depend on the presence or absence of SARS cases in the world.

**Att-Op-4D: Infection Control for Suspected Cases of SARS**

The following protocol for evaluation of patients hospitalized with radiographic evidence of pneumonia should be used when SARS activity worldwide is absent.

**1.** Evaluate for alternative diagnosis, which may include the following:

- **a.** CBC with differential
- **b.** Pulse oximetry
- **c.** Blood cultures
- **d.** Sputum Gram's stain and culture
- **e.** Tests for viral respiratory pathogens such as influenza and RSV

2. After 72 hours, if an alternate diagnosis has been found, treat and isolate according to the causative agent.

3. If an alternate diagnosis has not been found after 72 hours, and there are other reasons to suspect SARS, consider SARS testing in consultation with the state health department.

4. If SARS testing is determined necessary, place patient in standard, airborne, and contact isolation, and use eye protection for every patient contact.

The following protocol for evaluation of patients with fever or respiratory symptoms should be used when SARS activity has been detected anywhere in the world.

1. If the patient has had recent close contact with persons suspected to have SARS or exposure to locations where SARS transmission is suspected, initiate a preliminary work up and notify the state health department.

2. Perform SARS testing (in consultation with state health department) if there is radiographic evidence of pulmonary infiltrates.

3. Consult algorithm for further steps in case assessment and recommended isolation precautions.

## IV. Management of Suspect, Probable, and Confirmed SARS Cases

## Att-Op-4D: Infection Control for Suspected Cases of SARS

A. Isolation

1. Suspect SARS cases should be placed on airborne and contact precautions upon entrance to the facility.

2. It is recommended that the inpatient NPAir have a toilet, sink, and a bath or shower.

3. If NPAir rooms are NOT available, place patients in private rooms. Hospital personnel should wear fit-tested N-95 respirators when entering the rooms. If N-95 respirators are not available, health care workers evaluating and caring for SARS cases should wear a surgical mask.

4. Infection control personnel should be notified immediately of suspected SARS cases. They in turn will notify the local health department. If not already involved, consultations are to be requested from infectious disease specialists and/or pulmonary disease specialists.

5. Signs noting the need for airborne and contact precautions are to be displayed outside isolation rooms. Doors to isolation rooms should be kept closed (self-closing doors are preferable).

6. Eye protection is to be worn during contact with all suspect SARS cases. (*Note: Eye protection should protect the eyes from splashes from above and from the sides of the eyes.)*

7. If available, the suspected case is to be placed in "NPAir" with an anteroom that has a sink, so that persons leaving the room can dispose of their protective clothing and equipment and wash their hands before exiting to the hallway.

8. In the absence of an anteroom, gowns and gloves are to be removed inside the suspected case room and discarded in a waste receptacle just inside the room by the door. A separate waste receptacle is to be placed immediately outside the suspected case room for disposal of used respirators.

B. Traffic in Isolation Rooms

1. The number of persons entering isolation rooms should be minimized as much as possible. Visitors should be limited to:

   a. Designated public health officials.

b. Designated family members, determined by the local health department.

2. All staff and designated family members, prior to entering the room, are to be instructed in the meaning of contact, airborne and standard precautions.

a. Designated visitors must wear contact and airborne personal protection and eye protection when entering rooms of suspect cases, and should be offered assistance if needed.

b. All hospital and public health staff will have undergone fit testing for appropriate respiratory protection.

c. Information on all persons who had unprotected exposure to a suspect SARS case is to be kept in a logbook outside the isolation room. The names and job duty (*for hospital staff)* are to be recorded. Non-hospital staff and visitors are to provide names, work location, work phone number, home phone number, cellular phone number, and beeper numbers on the logbook. All information should be given to the local health department for purposes of contact tracing.

C. Patient Care Items and Equipment

1. Disposable items are to be used whenever possible.

2. After use, all disposable personal protective equipment is to be placed into regular trash in the isolation room (*gowns, gloves)* or outside of the room (*respirators).* Ideally, these are to be placed in the anteroom, if an NPAir with anteroom is available. N-95 respirators should not be re-used unless in short supply. If re-used, employ the following protocol: Wear a face shield or surgical mask over the respirator. Dispose of the surgical mask, or clean and disinfect the face shield after use. Remove the respirator, place in plastic bag, and hang in designated area.

3. As much as possible, dedicated patient care equipment (*e.g., blood pressure cuffs and stethoscopes)* is to be used for care of the suspected case and left in the patient's room. If equipment must be used on other patients (*e.g., portable X-ray machine),* all equipment must be cleaned and disinfected with EPA-registered hospital approved disinfectants (*e.g., quaternary ammonium compounds)*

a. The medical record is to be kept outside the room of the suspect case to prevent contamination. Maintain privacy of the medical record.

b. All non-essential equipment and supplies are to be removed from the room or protected from contamination (e.g. plastic sheet or drape) before the suspect case is admitted to the room.

c. Staff and others entering the room of the suspected case should keep any equipment and supplies (*e.g. phlebotomy*) to the minimum necessary.

d. It is not necessary to use disposable eating utensils, trays, or dishes for suspect SARS cases.

D. Patient Transport

1. The suspect case is to be kept in the isolation room except for medically essential procedures that cannot be done at the bedside.

2. Any movement of the suspect case outside of the isolation room should be done only in consultation with Infection Control staff.

3. If the suspect case needs to be transported, staff should ensure that no unauthorized persons enter the room while unoccupied.

4. To minimize the potential for contamination when transported outside of the "NPAir", a surgical mask is to be placed on the suspect case.

5. If staff involved in transporting the suspected case have direct contact with the suspected case (*e.g., contact with skin or oral secretions*) when moving the suspected case from his/her bed to the stretcher or wheel chair, their gowns and gloves may be contaminated.

   a. Prior to leaving the isolation room, staff should remove their personal protective equipment. All items should be decontaminatd before leaving patient room. This includes beds or wheelchairs used for transport. Transport staff should consist of two persons, one to have patient contact, if necessary, and the other to handle the bed, wheelchair, doors, and other items in the environment without contaminating them.

b. The departments receiving the patient for medical procedures (*e.g., radiology or surgery*) are to be notified prior to transport so that appropriate arrangements can be made for direct and immediate access to the procedure room.

c. The infection control precautions outlined above are to be followed by all hospital staff involved in the care of suspect cases while they are undergoing medical procedures outside the negative pressure airborne isolation room.

d. Transport equipment *(e.g., stretcher or wheelchair)* or equipment in the procedure room (*e.g., x-ray table)* should be cleaned with EPA-registered hospital approved disinfectants (*e.g., quaternary ammonium compounds).*

e. No one except the suspect case and transport staff should be present in elevators during transport.

E. Aerosol-Generating Procedures

Aerosol-generating procedures may increase the risk of SARS transmission. Health care workers present during such procedures should observe special precautions. See pages16-17 for infection control precautions during aerosol-generating procedures.

F. Laundry and Linens

1. Staff should handle all laundry and used linens carefully to avoid contact with potentially infectious material.

2. Anyone handling used linen or laundry should wear a gown and gloves.

G. Environmental Cleaning/Disinfection

1. Inpatient isolation rooms should be cleaned and disinfected daily and at time of transfer or discharge.

2. All equipment and surfaces, including such items as cubicle curtains, carpeting and upholstered items are to be cleaned according to contact isolation protocols with standard EPA-registered hospital disinfectants (*e.g., quaternary ammonium compounds).*

3. Before initiation of terminal cleaning and disinfecting of NPAir rooms, allow an appropriate period of time to elapse to ensure particulate removal, based on the ability of the affected hospital area HVAC system to achieve 6 to 12 air exchanges. Consult **Appendix V** of smallpox isolation guidelines to determine the amount of time required for particulate removal to occur. (*Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care facilities. MMWR 1994; 43 (R-13):page 72).* **Note:** The facility engineers should identify air exchange rates for each room/area in the hospital and post the air exchange rates per **Appendix V.**

4. Staff involved in cleaning and disinfection activities should wear full protective attire as required by contact isolation (disposable gowns, utility gloves). Fit-tested N-95 respirators and eye protection (face shields or goggles) should be worn while patients are in the rooms.

5. Solutions used for cleaning and disinfection should be discarded after being used in a SARS isolation room. Also thoroughly rinse and clean housekeeping equipment after use. Launder reusable mop heads and cleaning cloths according to current practice.

H. Laboratory Specimens

Care is to be taken when handling routine clinical laboratory specimens.

1. Laboratory requests are to be limited to those tests that are essential to patient management.

2. Laboratory staff should be trained in handling clinical specimens to understand that the risk of SARS infection due to contact with samples for a suspect case is low when handled appropriately.

3. All clinical specimens are to be placed in zip-lock bags that are tightly sealed and properly labeled prior to transport to the laboratory. Information indicating that the source is a suspect SARS patient should accompany the specimens to assure proper handling by laboratory staff.

4. Blood and urine specimens can be handled in the laboratory using standard precautions.

5. Refer to the following website for details on safe handling of laboratory specimens: http://www.cdc.gov/ncidod/sars/sarslabguide.htm

I. Removal of Personal Protective Equipment (PPE)

1. Disposable PPE is recommended for use whenever possible to allow for more convenient removal.

2. See page 18 for suggested method of PPE removal when using disposable PPE.

J. Discontinuation of Isolation/Discharge of Cases

1. Health care staff should notify the local health department when patients are ready for discharge. The local health department will make arrangements for appropriate post-discharge isolation or quarantine of SARS cases.

2. Patients may be removed from isolation 10 days after the time when their fever resolves and respiratory symptoms are absent or improving.

## V. Management of Close Contacts of Suspect SARS Cases

A close contact is defined as having cared for or lived with a person known to have SARS or having a high likelihood of direct contact with respiratory secretions and/or body fluids of a patient known to have SARS. Examples of close contact include kissing or embracing, sharing eating or drinking utensils, close conversation (<3 feet), physical examination, and any other direct physical contact between persons. Close contact does not include activities such as walking by a person or sitting across a waiting room or office for a brief period of time.

Quarantine of the hospital or any area of the hospital and diversion of patients is to be considered only in consultation with hospital administrative staff, infectious disease and infection control staff and the local health department.

A. Role of Local Health Department Staff

1. Any decisions to quarantine close contacts must be made by the local health department. Local health departments will make the necessary arrangements for appropriate isolation or quarantine.

2. All persons, including visitors and other patients in the Emergency Department, clinical area or other areas of the hospital who had “close contact” with a suspect SARS case should be referred to the local health

department to be monitored for development of fever or respiratory symptoms. Local health department staff should ensure that contacts record their temperature twice daily, watch for signs of respiratory illness, and report to local health department staff daily during the ten days after their last exposure to a suspect SARS case.

3. Local health department staff should instruct close contacts that develop fever or respiratory symptoms to:

    a. notify their health care providers immediately.
    b. notify the local health department immediately.
    c. alert their provider before seeking medical evaluation to ensure infection control measures will be in place at the time of their arrival to the facility.
    d. follow appropriate infection control measures in the home.
    e. limit activities outside of the home (e.g. school, work, daycare, etc.).

4. The local health department will interview and counsel all "close contacts" (*including emergency department and clinic staff, other patients, and visitors*), as well as review the educational materials (e.g., see **Appendix IV** of smallpox guidelines) and provide a 24-hour local health department telephone hotline number for all contacts to use if they have additional questions or concerns after leaving the hospital.

B. Role of Health Care Facility Staff

1. Known close contacts of suspect SARS cases should be screened for fever or respiratory symptoms before visiting health care facilities and should be excluded from visiting if they have either fever or respiratory symptoms.

2. Health care staff should assist the local health departments in determining those who may be close contacts of cases.

3. Health care facilities should maintain a logbook of all staff entering rooms of suspect SARS cases or who were otherwise involved in the patient's care, regardless of whether PPE was worn.

4. Staff should be instructed to watch for development of fever or respiratory symptoms during the 10 days after the last exposure to the suspect patient.

## VI. Management of Exposed Health Care Workers

A. Asymptomatic health care workers

1. Health care workers who have **unprotected high-risk exposures** to SARS should be excluded from duty (e.g. administrative leave) for 10 days following the exposure. Unprotected high-risk exposure is defined as presence in the same room as a probable SARS patient during a high-risk aerosol-generating procedure or event and where recommended infection control precautions are either absent or breached.

2. Health-care workers who are excluded from duty because of their exposure need not limit their activities outside of the healthcare setting, but should undergo active surveillance for symptoms, including measurement of body temperature twice daily and monitoring for respiratory symptoms for 10 days following exposure.

3. Health-care workers who have other unprotected exposures to patients with SARS need not be excluded from duty because of their exposure and need not limit their activities outside of the healthcare setting, but should undergo active surveillance for symptoms, including measurement of body temperature twice daily and monitoring for respiratory symptoms for 10 days following exposure.

5. Health-care workers who have cared for or otherwise been exposed to SARS patients while adhering to recommended infection control precautions should be instructed to be vigilant for fever and respiratory symptoms, including measurement of body temperature at least twice daily for 10 days following the last exposure to a SARS patient. These health-care workers should be contacted by occupational health, infection control or their designee regularly over the 10-day period following exposure to inquire about fever or respiratory symptoms.

B. Symptomatic health care workers

1. Any health-care worker who has cared for or been exposed to a SARS patient who develops fever OR respiratory symptoms within 10 days following exposure should not report for duty, but should stay home and report symptoms to the appropriate facility point of contact immediately. If

the symptoms begin while at work, the health-care worker should be instructed to immediately apply a surgical mask and leave the patient care area. Symptomatic health-care workers should use infection control precautions to minimize the potential for transmission and should seek health-care evaluation. **In advance of clinical evaluation health-care providers should be informed that the individual might have been exposed to SARS so arrangements can be made, as necessary, to prevent transmission to others in the health-care setting.**

2. If symptoms improve or resolve within 72 hours after first symptom onset, the person may be allowed after consultation with infection control and local public health authorities to return to duty and infection control precautions can be discontinued.

3. For persons who meet or progress to meet the case definition for SARS (e.g., develop fever and respiratory symptoms), infection control precautions should be continued until 10 days after the resolution of fever, provided respiratory symptoms are absent or improving.

4. If the illness does not progress to meet the case definition, but the individual has persistent fever* or unresolving respiratory symptoms, infection control precautions should be continued for an additional 72 hours, at the end of which time a clinical evaluation should be performed. If the illness progresses to meet the case definition, infection control precautions should be continued as described above. If case definition criteria are not met, infection control precautions can be discontinued after consultation with local public health authorities and the evaluating clinician

6. Persons who meet or progress to meet the case definition for suspected SARS (e.g., develop fever and respiratory symptoms) or whose illness does not meet the case definition, but who have persistent fever or unresolving respiratory symptoms over the 72 hours following onset of symptoms should be tested for SARS coronavirus infection.

*Clinical judgment should be used when evaluating patients for whom a measured temperature of >100.4º F (>38º C) has not been documented. Factors that might be considered include patient self-report of fever, use of antipyretics, presence of

immunocompromising conditions or therapies, lack of access to health care, or inability to obtain a measured temperature

## VII. Management of Suspect SARS Cases in Ambulatory Care Settings

SARS is transmitted predominately by close contact, however it is still important to identify persons who present in outpatient settings with symptoms consistent with SARS.

A. Triage

1. Staff should ask screening questions regarding fever, respiratory symptoms, travel history, and close contact with other SARS suspect cases when patients call in for an appointments, at triage, or as soon as possible after patient arrives.

2. The most recent case definition for SARS should be used as the basis for questions about travel history.

3. Staff that are first points of contact should be trained to do SARS screening and to take appropriate measures if a suspected SARS case is identified.

B. Infection Control

1. Infection control measures should be implemented for patients who have either fever or respiratory symptoms, and have had close contact with a SARS suspected case or who have a travel history to areas listed in the case definition.

2. Place a surgical mask on persons suspected of having SARS until they can placed in a private room or area. If they are unable to wear a mask, ask them to cover their mouths with disposable tissue when talking, sneezing, or coughing.

3. Practice standard precautions; in addition wear eye protection for all patient contact.

4. Patients should be placed in contact isolation. Wear gowns and gloves for all patient contact and contact with the patient environment.

5. If available, patient should be placed in an NPAir room. When such rooms are not available, place patient in private room and keep door closed. Portable HEPA filtration units are recommended for use if available.

6. All persons entering the patient's room should wear a fit-tested N-95 respirator. If not available, wear surgical masks when in the patient's room.

7. Patients should wear a surgical mask when they are outside of the isolation room.

## Att-Op-4D: Infection Control for Suspected Cases of SARS

### CDC SARS Case Definitions
### July 18, 2003

**Clinical Criteria**

- Asymptomatic or mild respiratory illness
- Moderate respiratory illness
    - Temperature of >100.4°F (>38°C)*, and
    - One or more clinical findings of respiratory illness (e.g., cough, shortness of breath, difficulty breathing, or hypoxia).
- Severe respiratory illness
    - Temperature of >100.4°F (>38°C)*, and
    - One or more clinical findings of respiratory illness (e.g., cough, shortness of breath, difficulty breathing, or hypoxia), and
        - radiographic evidence of pneumonia, or
        - respiratory distress syndrome, or
        - autopsy findings consistent with pneumonia or respiratory distress syndrome without an identifiable cause

**Epidemiologic Criteria**

- Travel (including transit in an airport) within 10 days of onset of symptoms to an area with current or previously documented or suspected community transmission of SARS (see Table below), or

- Close contact** within 10 days of onset of symptoms with a person known or suspected to have SARS.

## Table. Travel criteria for suspect or probable U.S. cases of SARS

| Area | First date of illness onset for inclusion as reported case | Last date of illness onset for inclusion as reported case |
|---|---|---|
| China (Mainland) | November 1, 2002 | July 13, 2003 |
| Hong Kong | February 1, 2003 | July 11, 2003 |
| Hanoi, Vietnam | February 1, 2003 | May 25, 2003 |
| Singapore | February 1, 2003 | June 14, 2003 |
| Toronto, Canada | April 1, 2003 | July 18, 2003 |
| Taiwan | May 1, 2003 | July 25, 2003 |
| Beijing, China | November 1, 2002 | July 21, 2003 |

The last date for illness onset is 10 days (i.e., one incubation period) after removal of a CDC travel alert. The case patient's travel should have occurred on or before the last date the travel alert was in place.

**Laboratory Criteria**

- Confirmed
  - Detection of antibody to SARS-associated coronavirus (SARS-CoV) in a serum sample, or
  - Detection of SARS-CoV RNA by RT-PCR confirmed by a second PCR assay, by using a second aliquot of the specimen and a different set of PCR primers, or
  - Isolation of SARS-CoV.
- Negative
  - Absence of antibody to SARS-CoV in a convalescent–phase serum sample obtained >28 days after symptom onset.
- Undetermined
  - Laboratory testing either not performed or incomplete.

## Att-Op-4D: Infection Control for Suspected Cases of SARS

### Case Classification

- Probable case: meets the clinical criteria for severe respiratory illness of unknown etiology and epidemiologic criteria for exposure; laboratory criteria confirmed or undetermined.
- Suspect case: meets the clinical criteria for moderate respiratory illness of unknown etiology, and epidemiologic criteria for exposure; laboratory criteria **confirmed or undetermined.**

### Exclusion Criteria

A case may be excluded as a suspect or probable SARS case if:

- A case may be excluded as a suspect or probable SARS case if:
- An alternative diagnosis can fully explain the illness.***
- The case has a convalescent-phase serum sample (i.e., obtained >28 days after symptom onset) for which is negative for antibody to SARS-CoV.
- The case was reported on the basis of contact with an index case that was subsequently excluded as a case of SARS, provided other possible epidemiologic exposure criteria are not present.

* A measured documented temperature of >100.4°F (>38°C) is preferred. However, clinical judgment should be used when evaluating patients for whom a measured temperature of >100.4°F (>38°C) has not been documented. Factors that might be considered include patient self-report of fever, use of antipyretics, presence of immunocompromising conditions or therapies, lack of access to health care, or inability to obtain a measured temperature. Reporting authorities should consider these factors when classifying patients who do not strictly meet the clinical criteria for this case definition.

**Close contact is defined as having cared for or lived with a person known to have SARS or having a high likelihood of direct contact with respiratory secretions and/or body fluids of a patient known to have SARS. Examples of close contact include kissing or embracing, sharing eating or drinking utensils, close conversation (<3 feet), physical examination, and any other direct physical contact between persons. Close contact does not include activities such as walking by a person or sitting across a waiting room or office for a brief period of time.

***Factors that may be considered in assigning alternate diagnoses include the strength of the epidemiologic exposure criteria for SARS, the specificity of the diagnostic test, and the compatibility of the clinical presentation and course of illness for the alternative diagnosis.

## Att-Op-4D: Infection Control for Suspected Cases of SARS

### Infection Control Precautions During Aerosol-Generating Procedures on Patients with SARS

During the initial outbreak of SARS, it was determined that aerosol-generating procedures performed on SARS patients may increase the risk of SARS transmission.

Health care workers should be informed that aerosol-generating procedures (e.g. aerosolized medication treatment, sputum induction, bronchoscopy, airway suctioning, endotrachial intubation, or positive pressure ventilation such as BiPAP, CPAP, HFOC) can increase the risk of transmission of SARS. The following precautions should be taken whenever aerosol-generating procedures must be performed.

**Limit opportunities for exposure.**

- Perform aerosol-generating procedures only when medically necessary.
- Use clinically appropriate sedation during intubation and bronchoscopy to minimize resistance and coughing during procedure.
- Only health care workers who are essential to patient care should be in the room when procedures are done.

**Perform procedures in appropriate settings.**

- If the patient is in an airborne isolation room, perform the procedure in that setting.
- If an airborne isolation room is not available, perform the procedure in a private room, away from other patients. If possible, increase air exchanges, create negative pressure relative to hallways, and avoid recirculation of room air. If recirculation is unavoidable, the air should be filtered through a HEPA filter as recommended for *Mycobacterium tuberculosis.*
- Keep door to rooms in which procedures are being done closed except when entering or exiting the rooms.
- Traffic in and out of rooms should be limited during procedures.

**Use filters on ventilation exhaust valves.**

- Although the effectiveness of filters is unknown, it may be prudent to use bacterial/viral filters on exhalation valves of ventilators to prevent contaminated aerosols from entering the environment.

**Wear personal protective equipment.**

- The optimal combination of personal protective equipment (PPE) to be worn during aerosol-generating procedures is still unknown.
- Current recommendations require PPE to cover the arms, torso, and fully protect the mouth, nose, and eyes.
- Consider additional PPE to cover all areas of skin.
- The following PPE is recommended for all those present during an aerosol-generating procedure:
  - Single isolation gown to protect body and exposed areas of arms. Use of a full-bodied isolation suit may be considered, as it provides greater protection for the neck area.
  - Single pair of disposable gloves that fit snugly over the wrists.
  - Eye protection consisting of goggles that fit snugly around the eyes.
  - Respiratory protection for aerosol-generating procedures must ensure that HCWs are protected from exposure to aerosolized infectious droplets through breaches in respirator seal integrity. Healthcare facilities should consider the following options:
    - Disposable particulate respirators (e.g. N-95, N-99, or N-100) are sufficient for routine respiratory protection for airborne precautions and are the minimum level of respiratory protection for HCWs who are performing aerosol-generating procedures. To ensure adequate protection, HCWs must be

fit-tested to the respirator model that they will wear (see TB Respiratory Protection Program In Health Care Facilities: Administrator's Guide).
    - A fit-check should be performed each time the respirator is put on.
    - At this time there is inadequate information to determine whether higher levels of respiratory protection (e.g. powered air purifying respirators,) will further reduce transmission. Factors that should be considered in choosing respirators in this setting include availability, impact on mobility and comfort.
- Suggested PPE that will fulfill requirements for concurrent respiratory protection and sealed eye protection:
    - Sealed goggles with NIOSH certified N-95 respirator, as long as fit-testing of the respirator can be achieved.
    - PAPR (powered air-purifying respirator) with loose fitting hood, and N-95 filters.
    - Full face respirator with N-95 filter.

**Adhere to safe work practices.**

- Aerosol-generating procedures have the potential to create high concentrations of the SARS virus in the air and on environmental surfaces. Avoid touching face or PPE on face with contaminated gloves. Avoid contaminating the surfaces around the patient and in the room.
- Use care when removing PPE to avoid contamination of skin, clothing, and mucous membranes (see guide for appropriate removal of PPE).
- Perform hand hygiene after removing PPE and before leaving patient room.

**Decontaminate PPE and environmental surfaces.**

- Decontaminate reusable PPE with an EPA registered hospital approved disinfectant.
- Wear clean gloves when wiping surfaces of equipment.
- Clean and disinfect horizontal surfaces in the room where aerosol-generating procedures have been done as soon as possible, and before other patients or health care workers enter the room.

## Att-Op-4D: Infection Control for Suspected Cases of SARS

### Procedure for Removing Personal Protective Equipment (PPE)

During the SARS outbreak in Toronto, it was thought that contaminated PPE may have been a potential source of infection of health care workers, thus the manner in which it is removed may be important. The following method is one suggestion for removing PPE while minimizing risk of contamination of clothing, skin, and mucous membranes. It is based on the use of disposable PPE, and utilizes the principle of removing PPE from the facial area with clean hands.

1. Before leaving the isolation room or ante room, remove the disposable gown by grasping it at the shoulders, pulling down, and rolling inside out. Keep the contaminated outside of the gown away from the body.

2. Remove gloves with the clean side of the gown while rolling it down. Keep hands on the clean side of the gown.

3. Gown and gloves may be disposed of in regular trash unless grossly soiled with blood or other body fluids.

4. Wash hand with soap and water or sanitize with alcohol gel.

5. Remove PPE from face (face shield, goggles) while inside the isolation room or anteroom, except for the N-95 respirator.

6. Immediately after leaving the isolation room or ante room, remove N-95 respirator, touching only straps at back of head and dispose of in regular trash.

7. Wash hands with soap and water or sanitize with alcohol gel. Do not touch face until hands are decontaminated.

# Att-Op-4E: Personal Protective Equipment Inventory Calculation Worksheet

## Background Information

**A.** Inventory Quantities

**1.** The recommendation of regional minimum inventory levels is described here for two scenarios:

**a.** Small Scale – Hospital Contained Event
**b.** Large Scale – Cohort Event

**2.** Regardless of the scale of the event and because of the Strategic National Stock Pile arrival timetable of 48 hours, it is recommended that each region maintain a PPE inventory that allows them to be self-sufficient for a minimum of 2 days.

**3.** Small Scale – Hospital Contained Event

**a.** A Small Scale Event assumes that the number of patients is low enough to allow each patient to be placed in a private Airborne Infection Isolation (AII) room and the caregiver removes all PPE between patients when leaving the room.

**b.** The inventory level may be calculate for a Small-Scale event as follows:

**1)** 40 PPE changes per day per AII rooms, where the number of days equals 2 and the number AII rooms equals the number of room available at a given hospital or region.

**2)** For example: For AII rooms, the formula would produce a total of 1600 PPE changes (40 PPE changes x 2 days x 20 rooms = 1600).

**c.** A calculation tool is provided below for determining inventory quantities for Small Scale events.

**4.** Large Scale – Cohort Event

**a.** A Large Scale event assumes a mass casualty number of, patients during which a cohort effort is needed. In this situation it may not be necessary or desirable to change all PPE items each time a patient is seen because there may be more than one patient in each room.

**Att-Op-4E: Personal Protective Equipment Inventory Calculation Worksheet**

**b.** The inventory level may be calculated for a Large Scale event as follows:

**1)** 20 PPE changes per day, where the number of days equals 2, times the HRSA recommended minimum patient planning number of 500 for rural areas and 1000 for metropolitan areas.

**2)** For example: For a rural region, the formula would produce a total of 20,000 PPE changes (20 PPE changes x 2 days x 500 patient = 20,000). Similarly the recommended minimum for 1000 patient population would be 80,000 changed of PPE.

**B.** Inventory Storage and Distribution

**1.** There are three general approaches for storing and PPE inventory.

**a.** A de-centralized approach in which the total regional inventory is divided up among the hospitals in the region. This approach has the advantage of allowing for variability between inventory brand items based on user preference. However, this advantage poses some issues, such as fit-testing of respirators, if the transfer of inventory between hospitals is needed.

**b.** A centralized approach in which the total regional inventory is maintained in one or two locations within the region. Provisions to allow all regional facilities to draw on the inventory are to be established. The advantage of this approach is that the inventory is less likely to deteriorate over time and promote a standardized inventory. The disadvantages are that additional planning for distribution is needed and the costs imposed by the storage facility itself.

**c.** A combination approach of the first two. It may be determined that a de-centralized approach would be applied to a small scale, hospital based event and the centralized approach to a large scale, cohort event. This approach will provide a ready inventory at each hospital during the onset of an event, before the magnitude of the event is determined. Then, if the event expands additional supplies would be available regionally.

**Att-Op-4E: Personal Protective Equipment Inventory Calculation Worksheet**

**2.** Generally, any PPE storage and distribution method is to be designed to address turnover, expiration dates and obsolescence.

**Att-Op-4E: Personal Protective Equipment Inventory**
**Calculation Worksheet**

## Calculation Worksheet

The completion of this worksheet by the hospital will result in the amount of

- PPE necessary to hold in inventory in preparation for an infectious disease outbreak
- The funding amount available to the hospital through its Regional Hospital Preparedness Team to purchase this inventory

1. Name of Hospital _____

2. Number of existing Airborne Infection Isolation rooms (AII): _____

   Note: Please take the number of AII from the "Survey of Wisconsin Hospitals on Isolation Capacity", which your facility has just completed. If this number is erroneous, please insert the correct number and provide the name and phone number for the person we can contact to correct the information on the survey:

   Contact Person: _____ Phone Number _____

3. If your hospital has no negative pressure airborne isolation rooms in the ED, then provide the number of beds available in your Emergency Department: _____

4. The total number of rooms for your hospital for the purpose of this worksheet is the SUM of #2 and #3: _____

5. Complete the following formula:

   **40 PPE Changes/Day multiplied by the _____ Number of rooms (from #4 above) multiplied by 2 days = _____ Changes of PPE Necessary**

**Att-Op-4E: Personal Protective Equipment Inventory Calculation Worksheet**

6. Cost and Case Quantities: Please provide the following information for each item of PPE listed below:

   Note: The person completing this survey will usually need to obtain this information from the Director of Materials Management. The 'usual and customary" cost per case is expected purchase price of each of these items, if they were to be purchased within the next few months.

| PPE | Quantity Per Case | Expected Purchase Price |
|---|---|---|
| N 95 Respirators | | |
| Gloves | | |
| Gowns | | |
| Shoe Covers | | |
| Eye Protection | | |

7. Normal Inventory: Please provide the number of cases for each item of PPE that the hospital keeps in inventory on a regular basis along with the Brand Name of the PPE:

   Note: The person completing this survey will usually need to obtain this information from the Director of Materials Management. It is assumed that each hospital stocks a variety of sizes based on its historical needs. Only the total amount of cases for each item needs to be listed here.

| PPE | Brand Name | # of Cases in Normal Inventory |
|---|---|---|
| N 95 Respirators | | |
| Gloves | | |
| Gowns | | |
| Shoe Covers | | |
| Eye Protection | | |

8. Recommended Inventory: The following formula will establish the inventory that is recommended for the PPE changes that resulted from the formula in Question #5.

   a. **N 95 Respirators**: _____ Changes of PPE (number from Q#5) divided by the quantity per case (number from Q#6) = _____ Number of Cases Recommended for Inventory
   b. **Gloves**: _____ Changes of PPE (number from Q#5) divided by the quantity per case (number from Q#6) multiplied by 2* = _____ Number of Cases Recommended for Inventory
   c. **Gowns**: _____ Changes of PPE (number from Q#5) divided by the quantity per case (number from Q#6) = _____ Number of Cases Recommended for Inventory

**Att-Op-4E: Personal Protective Equipment Inventory Calculation Worksheet**

d. **Shoe Covers**: _____ Changes of PPE (number from Q#5) divided by the quantity per case (number from Q#6) = _____ Number of Cases Recommended for Inventory
e. **Eye Protection**: _____ Changes of PPE (number from Q#5) divided by the quantity per case (number from Q#6) = _____ Number of Cases divided by 4 = _____ Number of Cases Recommended for Inventory

Note: Eye protection is required only when the staff person is in close proximity to a patient who is coughing or if there is a procedure that may involve a splash. Thus, the quantity required is less than for other items of PPE.

* It is assumed that gloves are packaged individually and not as sets. Thus, a box of 100 gloves contains 50 sets of gloves. If gloves come packaged as sets, then there is no need to multiply by 2.

9. PPE Inventory Gap to be funded by the Regional Hospital Preparedness Team: The following formula will result in the "gap" inventory, which is the difference between the Recommended Inventory and the Normal Inventory.

   Instructions:

   a. In Column B insert the Recommend Inventory from Question #8.
   b. In Column C insert the Normal Inventory from Question # 7.
   c. In Column D insert the difference by subtracting Column C from Column B

| PPE | Column B | Column C | Column D |
|---|---|---|---|
| N 95 Respirators | | | |
| Gloves | | | |
| Gowns | | | |
| Shoe Covers | | | |
| Eye Protection | | | |

10. Inventory: It is necessary to determine whether the inventory of the Recommended Inventory level will present storage or other logistical problems for the hospital.

    Note: These questions may need to be answered by the Director of Materials Management in consultation with Administration.

    a. Can the above quantities be inventoried at your hospital?

       - ❑ Yes
       - ❑ No

**Att-Op-4E: Personal Protective Equipment Inventory Calculation Worksheet**

b. If No, is there an alternative storage area at your hospital where the "gap" inventory may be stored?

- ❑ Yes
- ❑ No

c. Do you have any other comments on the storage of this Recommended Inventory?

11. Grant Funds Available to Hospital: This formula will result in the amount of funding that the hospital will receive from the Regional Hospital Preparedness Team to increase its Normal Inventory of PPE to the Recommended Inventory.

    Instructions:

    a. In Column B insert the number of cases for the "gap" inventory from Column D in Question #9.
    b. In Column B insert the cost per case from Question #6.
    c. In Column C multiply Column B by Column C
    d. In Column C under TOTAL, insert the sum of the costs for Rows a, b, c and d.

| | PPE | A<br>Number of "Gap" Cases | B<br>Cost/Case | C<br>Amount |
|---|---|---|---|---|
| **A** | N 95 Respirators | | | |
| **B** | Gloves | | | |
| **C** | Gowns | | | |
| **D** | Shoe Covers | | | |
| **E** | Eye Protection | | | |
| **F** | TOTAL | | | |

12. The Total Amount in Row F is the amount of funding that will be provided to the Hospital by the Regional Hospital Team to purchase the Recommended Level of Inventory of PPE.

**Disclaimer**: This worksheet is an estimate only. It is possible that both the funding amounts and Recommended Inventory levels could be reduced or increased, based on the total amounts resulting from the completion of these worksheets by all hospitals in the region.

# Att-Op-4F: Procedure for Use, Maintenance, and Removing Personal Protective Equipment (PPE)

**A.** Use and Maintenance Issues

**1.** Respirator Fit-Testing: A recent OSHA clarification on the applicability of its TB Respiratory Protection Standard (1910.139) to other biological situations indicates that this standard will not apply. Rather, the broader Respiratory Protection Standard (1910.134) does apply. This broader standard requires, among other things, the use of a medical screening questionnaire and annual fit-testing. Because of this, each region or each participant hospital is to determine if a proactive or reactive testing method is to be implemented.

**2.** Re-use or Extended Use of Selected PPE Items**.** Applying standard infection control practices each participant hospital is to determine the re-use and extended use expectations for each type of PPE employed.

**B.** Removal

**1.** During the SARS outbreak in Toronto, it was thought that contaminated PPE may have been a potential source of infection of health care workers, thus the manner in which it is removed may be important. The following method is one suggestion for removing PPE while minimizing risk of contamination of clothing, skin, and mucous membranes. It is based on the use of disposable PPE, and utilizes the principle of removing PPE from the facial area with clean hands.

**a.** Before leaving the isolation room or ante room, remove the disposable gown by grasping it at the shoulders, pulling down, and rolling inside out. Keep the contaminated outside of the gown away from the body.

**b.** Remove gloves with the clean side of the gown while rolling it down. Keep hands on the clean side of the gown.

**c.** Gown and gloves may be disposed of in regular trash unless grossly soiled with blood or other body fluids.

**d.** Wash hand with soap and water or sanitize with alcohol gel.

**e.** Remove PPE from face (face shield, goggles) while inside the isolation room or anteroom, except for the N-95 respirator.

**Att-Op-4F: Procedure for Use, Maintenance, and Removing Personal Protective Equipment (PPE)**

**f.** Immediately after leaving the isolation room or ante room, remove N-95 respirator, touching only straps at back of head and dispose of in regular trash.

**g.** Wash hands with soap and water or sanitize with alcohol gel. Do not touch face until hands are decontaminated.

# Att-Op-6A: Field Medical Command

## Purpose

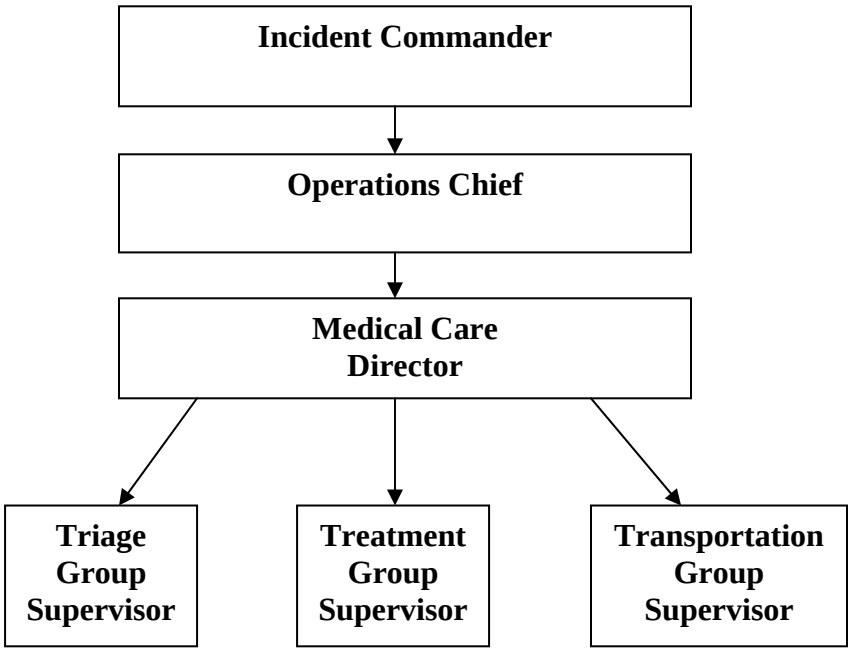
The purpose of this attachment is to provide a general description of the upper command levels at an incident scene. Specifically, it will focus on the command organization at the incident scene for medical response activities.

## Scope

The scope of this attachment will define the upper levels of command organization at an incident scene, general description of responsibilities for those positions, basic interface with a County/Tribal Emergency Operating Center (EOC) if established, and basic communication information.

## Concept of Operation

Below is a basic diagram of the command organization at an incident scene.



## Att-Op-6A: Field Medical Command

**A.** The Incident Commander will provide overall management for the incident scene. The Incident Commander will direct the activities of four sectional chiefs, one of which will be the Operations Chief. One of the branches of the Operation Section is the Medical Branch with a director assigned to oversee the activities of this branch. Depending on the size of the incident and available personnel, the Medical Branch Director may further delegate and assign duties to the Triage Group Supervisor, the Treatment Group Supervisor and the Transportation Group Supervisor.

**1.** The Triage Group Supervisor is responsible for initiating the Triage Function, which is to sort and categorize all patients.

**2.** The Treatment Group Supervisor is responsible for initiating the Treatment Function, which is to provide on-scene treatment of patients.

**3.** The Transportation Group Supervisor is responsible for ensuring that all patients are transported to an appropriate facility. In the early stages of an incident and before an EOC is activated, the Transportation Group Supervisor will coordinate with the 911 Center and the hospital(s) in the affected county or tribal nation.

**B.** After an EOC is activated, the Transportation Group Supervisor will communicate with the hospital EOC representatives in their respective County/Tribal EOCs to coordinate the transport of patients to the appropriate facility.

**C.** The hospital EOC representatives and the Emergency Medical Services (EMS) representatives in the affected County/Tribal EOC are to assist in transportation coordination activities.

**D.** The Transportation Group Supervisor is to relay basic information such as the number of victims by treatment priority category, an Estimated Time of Arrival (ETA), and the transporting ambulance identification (service/unit number). The receiving hospital or the EOC may advise the Transportation Group Supervisor to divert patients to other participant institutions.

**1.** In support of the overall transportation activity, each EMS unit transporting victims to a participant hospital will communicate directly to provide available patient information and confirm their ETA to the receiving hospital.

**2.** Under the Wisconsin Hospital Emergency Preparedness Plan (WHEPP), each participant hospital is to have available alternate communications systems, including, but not limited to:

## Att-Op-6A: Field Medical Command

**a.** EMS radio frequencies,

**b.** Emergency Room telephone number(s),

**c.** Incident control telephone number(s) and/or Incident Command Center

**d.** Cellular or other telephone numbers for the above locations that may be used in case there is a failure of normal systems.

**e.** The preferred method for contacting the hospital Incident Commander for each participating hospital (pager, phone, switchboard, etc.).

# Att-Op-6B: Patient Field Triage

## Purpose

The purpose of this attachment is to define the method to be used to identify and record the status of patient health prior to departure for a participant hospital, and the incorporation of this information into hospital records.

## Scope

The scope of this Attachment will cover the four treatment priority categories to be applied, the mandatory and "supplemental" information on patient status, and the link of information from the incident scene and the hospital.

## Concept of Operation

**A.** The Medical Care Director, through the Triage Group Supervisor, is responsible for not only initial treatment, but also assigning a treatment priority category for each patient and documenting the patient's condition, treatment, and personal information.

**B.** Each patient is to be classified into one of four treatment priority categories that serve as the basis for subsequent actions. These categories are:

| Priority | Patient Condition | Corresponding Color Code |
|---|---|---|
| Category I | Immediate Care | Red |
| Category II | Delayed Care | Yellow |
| Category III | Minor Injury | Green |
| Category 0 | Expired | Black |

**C.** Each patient routed to a participant hospital is to be tagged with an Emergency Medical Service (EMS) "Triage Tag" that can provide a variety of medical and personal information. Some of this information is considered mandatory and some supplemental. The MANDITORY information is to include:

1. Date and Time
2. Triage Tag Identification Number
3. Treatment Priority Category

**D.** Time permitting, the following SUPPLEMENTAL patient information is also to be provided:

1. Physical Assessment (Pictograph of injuries and vital signs information)
2. IV/IM Information and Time (if appropriate)
3. Patient Identification Information (names and address, if available)
4. Treatment Notes

**E.** Each participant hospital is to develop and maintain a method for recording and correlating the EMS Triage Tag ID number assigned to a patient at the incident scene, with a patient number assigned that individual upon arrival at the hospital, such as, an account number or similar number. This may be accomplished by whatever means each hospital determines is the most appropriate and feasible, such as, a log sheet or computer database.

# Att-Op-6C: Incident Termination

**Purpose**:

The purpose of this attachment is to provide pre-hospital and hospital guidance on actions needed when field medical response actions can be secured at the incident scene.

**Scope**:

The scope of this section will cover the actions of the Medical Commander at the incident scene, hospital representative in the County/Tribal Emergency Operating Center (EOC), and the hospitals supporting the incident.

**Concept of Operation**:

**A.** Pre-Hospital Termination

**1.** Upon completion of incident scene medical triage, treatment and transportation activities, the Medical Commander is to notify the EOC or Base Hospital that the medical response activity at the incident scene is terminated pre-hospital.

**2.** The hospital representative in the EOC is to notify all participant hospitals, activated under the WHEPP, that the medical activity at the event scene is terminated pre-hospital.

**3.** Each participant hospital is to notify any support providers, such as immediate care services which it activated under the WHEPP, that the pre-hospital medical activity at the event scene is terminated pre-hospital.

**B.** Hospital Termination

**1.** Termination at any individual hospital is to be based on that hospital's criterion for emergency or mass casualty response procedure.

**2.** Hospitals that terminate their emergency or mass casualty response activities are to notify either the Base Hospital or the activated EOC as is appropriate.

**3.** If the hospital terminating their emergency or mass casualty response activities is the Base Hospital, they are to notify all supporting hospitals of their decision.

## Att-Op-7A: HOSPITAL BED CAPACITY AND PATIENT CENSUS REPORT

FACILITY NAME_____TOWN/CITY:_____ DATE: _____ TIME: _____

PERSON COMPLETING REPORT: _____PHONE: _____

| INPATIENT BED CAPACITY AND PATIENT CENSUS REPORT | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Type of Unit** | **Bed Capacity** | | **Occupied Beds** | | **Expanded Bed Capacity** | | **Green Will Discharge** | | **Yellow** | **Red** | **Potentially Available Beds** | |
| | **A** | **B** | **C** | **D** | **E** | **F** | **G** | **H** | **I** | **J** | **K** | **L** |
| | **Regular** | **Neg Press** | **Reg** | **Neg Press** | **Reg** | **Neg Press** | **Reg** | **Neg Press** | | | **Reg** | **Neg Press** |
| Med Surg adults | | | | | | | | | | | | |
| Med Surg Monitored Adult | | | | | | | | | | | | |
| Behavioral health | | | | | | | | | | | | |
| OB/Gyn | | | | | | | | | | | | |
| Pediatric General | | | | | | | | | | | | |
| Peds ICU | | | | | | | | | | | | |
| Neonatal ICU | | | | | | | | | | | | |
| Critical Care Beds: Medical, Trauma and Neuro | | | | | | | | | | | | |
| Step-down Critical Care | | | | | | | | | | | | |
| Specialty Adult ICU (transplant/burn) | | | | | | | | | | | | |
| Other (specify) | | | | | | | | | | | | |
| Other (specify) | | | | | | | | | | | | |
| Other (specify) | | | | | | | | | | | | |
| **Total Inpatient beds** | | | | | | | | | | | | |



Version: 3
Date: 8-27-2004

## Att-Op-7A: HOSPITAL BED CAPACITY AND PATIENT CENSUS REPORT

| SURGICAL AND OUTPATIENT BED CAPACITY, OTHER RESOURCES AND, PATIENT CENSUS | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Type of Unit** | **Bed Capacity** | | **Occupied Beds** | | **Expanded Bed Capacity** | | **Green** | | **Yellow** | **Red** | **Potentially Available Beds** | |
| | **A** | **B** | **C** | **D** | **E** | **F** | **G** | **H** | **I** | **J** | **K** | **L** |
| | **Reg** | **Neg Press** | **Reg** | **Neg Press** | **Reg** | **Neg Press** | **Reg** | **Neg Press** | | | **Reg** | **Neg Press** |
| Surgical Suites | | | | | | | | | | | | |
| Emergency Department | | | | | | | | | | | | |
| Outpatient Services (Surgicenter, Endoscopy, etc.) | | | | | | | | | | | | |
| Pain Clinic | | | | | | | | | | | | |
| Dialysis | | | | | | | | | | | | |
| Urgent Care | | | | | | | | | | | | |
| Swing bed or attached Nursing Home | | | | | | | | | | | | |
| Rehabilitation | | | | | | | | | | | | |
| Other (specify) | | | | | | | | | | | | |
| Other (specify) | | | | | | | | | | | | |
| Other (specify) | | | | | | | | | | | | |
| **Total Outpatient beds** | | | | | | | | | | | | |

## Att-Op-7A: HOSPITAL BED CAPACITY AND PATIENT CENSUS REPORT

**IT IS IMPORTANT TO DATE AND TIME EACH REPORT AND INDICATE THE NAME AND NUMBER OF A CONTACT FOR UPDATED INFORMATION.**

### GUIDELINES FOR COMPLETING THE "HOSPITAL CAPACITY AND PATIENT CENSUS REPORT"

**The rows of this form may be altered to suit individual hospitals inpatient and outpatient services. The columns should remain unaltered for consistency of assessing bed availability and patient census.**

**Bed Capacity**: Indicate the number of hospital beds currently used for patient care on each unit. Include occupied and unoccupied beds. Separate negative pressure beds from regular beds into 2 columns.

**Occupied Beds**: Indicate the total number of occupied beds. Separate occupied negative pressure beds from occupied regular beds into 2 columns.

**Expanded Bed Capacity**: Indicate the number of beds available after implementing procedures to increase inpatient bed capacity. If these beds are located in spaces that are not fully equipped for patient care including medical gas, indicate the limitations on a separate page. All spaces should have access to bathrooms. Separate additional negative pressure beds from additional regular beds into 2 columns.

**Green:** Indicates patients, which are eligible for early discharge or may be cared for at home with home health care or in a nursing home setting. They may be transferred using private vehicles or patient transport vehicles or discharged from outpatient areas. **Note as these patients may be discharged, their number will be included in the number of potentially available beds. They are divided into regular and negative pressure beds for that reason.**

**Yellow:** Indicates patients, which require continued hospitalization, but do not require critical care resources during transfer and may be placed on a general inpatient unit. They may require ambulance transfer or patient transport vehicles.

**Red:** Indicates inpatients, which require critical care resources (life-sustaining medication, mechanical ventilation, hemodynamic stabilization). These patients require continued hospitalization and advanced life support personnel for ambulance transfer. They will require placement in a critical care unit upon transfer.

**Potentially Available Beds:** This number is derived by subtracting the beds that are occupied, adding the numbers of each type of bed that is available and adding the number of Green (or dischargeable) patients to come up with a number of potentially available beds, both regular and negative pressure. Use the alphabetically labeled columns and the following formulas to determine potentially available beds.

## Att-Op-7A: HOSPITAL BED CAPACITY AND PATIENT CENSUS REPORT

K= (A-C) +E+G
L=(B-D) +F+H

**NOTE. These definitions for acuity levels are developed for the purpose of increasing bed capacity and may differ from other acuity categories used by hospitals. These categories may be used for evacuation planning or preparation for a large influx of patients.**

**IT IS IMPORTANT TO DATE AND TIME EACH REPORT AND INDICATE THE NAME AND NUMBER OF A CONTACT FOR UPDATED INFORMATION.**

## Att-Op-10A: Decontamination Personal Protective Equipment

The recommended Decontamination Equipment that hospitals are to have will include the following:

A. Each hospital is to have a minimum of 18 Decontamination Suits – 12 ready for use and 6 that can be used for training purposes. These Decontamination Suits are to be inventoried at the following minimum quantities according to the following recommended specifications:

1. Decontamination Suits (18)

    a. The suit is to be Level C, Tyvek F or higher
    b. Seams are to be sealed and not sewn
    c. A hood is not required as the PAPR is hooded
    d. The suit is to have integrated boots with a gator

2. Gloves (18 pair)

    a. Inner gloves: nitrile exam gloves
    b. Outer gloves: green nitrile gloves to allow for dexterity

3. Silver Shield Gloves (20 pair)

4. Boots (18 pair) are to be non-latex rubber or nitrile overboots

B. Each hospital is to have a minimum of 6 PAPRs (Positive Air-Filtering Respirator). These PAPRs are to be inventoried at the following minimum quantities according to the following recommended specifications per PAPR:

1. 3M Hooded Breathe Easy 10 or equivalent, including:
2. butyl rubber hood
3. connecting hose and cover
4. turbo unit
5. 12 hour Lithium battery
6. (for training use only) NiCad battery, 1 battery charger and 3 training filter cartridges
7. FR 57 filter cartridges (6 filter cartridges per unit)
8. 2 additional butyl hoods to serve as replacements.

**Att-Op-10A: Decontamination Personal Protective Equipment**

C. Each hospital is to have a minimum of 100 Patient Pre/Post Decontamination Kits. These Patient Pre/Post Patient Decontamination Kits are to be inventoried at the following minimum quantities according to the following recommended specifications:

1. Patient Pre-Decontamination Kit

    a. Modesty Garment
    b. Personal Belongings Bag with barcode
    c. Contaminated Clothing Bag with barcode
    d. Marking Pen

2. Patient Post-Decontamination Kit
    a. Disposable towel
    b. Modesty Garment
    c. Disposable slippers
    d. Identity band with barcode

3. Kit Specifications
    a. Both kits must be contained in one bag
    b. Contaminated Clothing Bag must not contain any symbols other than wording to identify the contents as “Contaminated Clothing and the barcode.
    c. Barcode must also have readable numbers for identification purposes.
    d. Both the Pre and Post Kits must contain instructions in English.
    e. Modesty Garments are to be “one-size fits all”
    f. Modesty Garments must have belt-like tie strings or equivalent so that pediatric patients can shorten/tighten the Modesty Garment if necessary.
    g. Valuables Bag must be opaque.
    h. Valuables Bag and Contaminated Clothing Bags must be sealable

## Att-Op-10B: Specifications for Fixed Decontamination Rooms

| SPECIFICATIONS |
|---|
| 1. The public entrance to the decontamination space is to be a separate, independent, secured external entrance in close proximity to the ER. |
| 2. The decontamination space is to have an internal exit with access to the ER. |
| 3. There are to be engineered controls so that no air from the Hot or Warm Zone can enter the ER or any part of the hospital. |
| 4. Air in the decontamination space is to be negative in pressure, separate from the in-house system and exhausted to the outside of the facility. |
| 5. Ceiling, wall and floor finishes are preferably to be smooth, nonporous, scrub able, non-absorptive, non-perforated, capable of withstanding cleaning with and exposure to harsh chemicals, non-slip, and without crevices or seams. Floor shall be self-coving. |
| 6. All electrical outlets and equipment in the decontamination space are to be engineered for a wet environment. |
| 7. The decontamination space is to have a minimum of 2 wall/ceiling mounted hand hoses with tepid water supply, including anti-scald/freeze valves. |
| 8. The decontamination space is to have curtains or other devices to allow for patient privacy to the extent possible. |
| 9. The decontamination space is to be appropriately heated and air-cooled. |
| 10. Water drainage must be contained and disposed of safely according to applicable state and local regulations and code requirements. |
| 11. The decontamination space must be of sufficient size to accommodate non-ambulatory patients with the ability to maneuver two gurneys and space sufficient for a minimum of three staff to logroll the non-ambulatory patient. |
| 12. The decontamination space is to have a method to allow for communication between staff within and outside the decontamination space. |

# Att-Op-10C: Minimum and Enhanced Specifications for Decontamination Curriculum

## A. Introduction to Training for Decontamination

1. The mission of hospitals is to protect the health and safety of the people hospitals serve in an incident, involving the use of nuclear, biological or chemical agents:

    a. staff and their families
    b. patients and their families
    c. the community

2. There are three decontamination scenarios:

    a. to care for individuals on a day-to-day basis in need of decontamination
    b. to care for multiple patients in need of decontamination
    c. to care for large numbers of patients in need of decontamination

3. Training in decontamination is necessary so that staff know how:

    a. to use decontamination equipment
    b. to protect themselves, others and the facility
    c. properly to decontaminate the patient
    d. to maintain competency in these areas
    e. to be in compliance with regulatory agencies

4. These minimum specifications can be used as a "checklist" by hospitals in assessing various training curricula and instructors. The specifications can also be used as a "checklist" by the instructors/vendors to adapt their training curricula to the needs of Wisconsin hospitals

## B. Checklist for Hospital Enhanced First Reserve Awareness Training

1. First Receivers are defined as those

    a. who are likely to witness or discover a hazardous substance release
    b. who have been trained to initiate an emergency response sequence by notifying the proper authorities of the release
    c. who will take no further action beyond notifying the authorities of the release

**Att-Op-10C: Minimum and Enhanced Specifications for Decontamination Curriculum**

2. **Minimum Specifications for Awareness Training**: First Receivers are to receive sufficient training or sufficient experience to objectively demonstrate competency in the following areas:

**Awareness Training**
***OSHA Required Specifications***

**Awareness Specification 1**: understanding of what hazardous substances are and the risks associated with them

**Awareness Specification 2**: understanding of the potential outcomes associated with an emergency created when hazardous substances are present

**Awareness Specification 3**: ability to recognize the presence of hazardous substances in an emergency

**Awareness Specification 4**: ability to identify the hazardous substances, if possible

**Awareness Specification 5**: understanding of their role in the employer's (hospital's) emergency response plan, including site security and control

**Awareness Specification 6**: the ability to realize the need for additional resources, and to notify the appropriate authority

**Awareness Training**
***OSHA Enhanced Specifications***

**Awareness Specification 7**: understanding of the properties of WMD agents, including biologicals, and their effects

**Awareness Specification 8**: understanding of potential outcomes to the hospital associated with WMD agents, including biologicals

**Awareness Specification 9**: ability to recognize and react appropriately to a contaminated patient, including visual, odor, and cognitive clues the patient may be exhibiting

**Att-Op-10C: Minimum and Enhanced Specifications for Decontamination Curriculum**

## C. Checklist for Hospital Enhanced Operations Training

1. Operations Training is intended for those:

   a. Who respond to releases or potential releases of hazardous substances as part of the initial response for the purpose of protecting nearby persons, property or the environment from the effects of the release
   b. who are trained to respond in a defensive fashion without actually trying to stop the release
   c. whose function is to contain the release from a safe distance, keep it from spreading and prevent exposures

2. **Minimum Specifications for Operations Training**: Receivers at the Operational Level are to have at least eight hours of training or sufficient experience to objectively demonstrate competency in the following areas:

**Operations Training**
***OSHA Required Specifications***

**Operations Specification 1:** knowledge of basic hazard and risk assessment techniques

**Operations Specification 2:** Know how to select and use proper personal protective equipment, appropriate for this level

**Operations Specification 3:** An understanding of basic hazardous materials terminology

**Operations Specification 4:** Know how to perform basic control, containment and/or confinement operations within the capabilities of the resources and PPE available

**Operations Specification 5:** how to implement basic decontamination procedures

**Operations Specification 6:** An understanding of the relevant standard operating and termination procedures.

**Att-Op-10C: Minimum and Enhanced Specifications for Decontamination Curriculum**

## Operations Training
## *OSHA Enhanced Specifications*

**Operations Specification 7:** basic toxicology as it relates to effects of chemicals on the body

**Operations Specification 8:** identifying other information sources, such as patient, workplace, job function, etc. in order to determine contaminate identity

**Operations Specification 9:** detailed understanding of the Emergency Response Guidebook and NIOSH Guidebook, ATSDR vol. III, (http//micromedex.hosp.wisc.edu), Emergency Care for Hazardous Materials Exposure, and State of Wisconsin Chem – Bio Handbook (Jane's)

**Operations Specification 10:** hands-on exercises to familiarize themselves with using these resources.

**Operations Specification 11**: examining contaminated patient traffic flow as it relates to hospitals

**Operations Specification 12:** security concerns for hospitals, receiving contaminated patients

**Operations Specification 13:** advanced decontamination training, including hands-on exercises, wound management and care, patient relations, and protocols to deal with WMD agents, biological agents, and radioactives

**Operations Specification 14:** integration of decontamination operations into the Incident Command System of the hospital

**Operations Specification 15:** incident termination and clean-up of decontamination areas, including wastewater disposal options

**Operations Specification 16**: the basic HAZWOPER curriculum is to be be adapted to the hospital setting; HAZWOPER curriculum not relevant to the hospital setting is to be summarized or de-emphasized

**Operations Specification 17**: curriculum is to address chemicals found in the service area of the hospital (This listing is accomplished by the hospital through its Hazards Vulnerability Analysis and is to be provided to the instructor)

**Att-Op-10C: Minimum and Enhanced Specifications for Decontamination Curriculum**

## ***Specifications for Instructors***

**Instructor Specification 1**: The instructor is to be certified at least one level above the level at which he/she is to be instructing. The instructor is to provide a copy of his/her certification.

**Instructor Specification 2**: The instructor is to be recertified at annually. The instructor is to provide a copy of his/her certification.

**Instructor Specification 3**: The instructor is to have knowledge of hospital operations. The instructor is to provide one or both of the following documentation of this skill:

a. References, demonstrating to which hospitals he/she has provided this instruction

b. Documentation of hospital work experience

## Att-Op-12A: Document Glossary

**Dispensing Site**: A location/locations that is determined by the Local Public Officer and/or regional hospital to distribute pharmaceuticals and medical supplies in the case of a bioterrorism event.

**Emergency Operations Center (Local):** Official or unofficial center of operations during a mass casualty event.

**Medical Equipment**: Biomedical supplies such as ventilators, monitors, needed to function during a high influx of patients.

**Medical Supplies**: Materials needed to administer pharmaceuticals such as syringes, needles, etc.

**Pharmaceutical Supply House**: Privately owned business within Region.

**Regional Hospital**: Hospital within current designated region.

**Regional Hospital Bioterrorism Preparedness Team**: State oversight committee to provide leadership for all hospitals within designated region to ensure a bioterrorism plan is in place for their community.

**Regional Pharmacy**: Pharmacy within region that can serve as a stockpile site for pharmaceuticals.

**Stockpile Oversight Committee**: Appointed individuals to serve as a management team for the distribution and inventory control for the cache of pharmaceuticals for a bioterrorism event.

**Stockpile Site**: Place determined by each region to the location/locations for a cache of pharmaceuticals and medical supplies necessary to initially treat victims and caregivers until the Strategic National Stockpile arrives.

**Strategic National Stockpile (National Pharmaceutical Stockpile**): A national repository of pharmaceuticals and medical supplies that may be needed in the event of a biological or chemical terrorist incident to supplement and re-supply State and Local Public Health Agencies and hospitals.

## Att-Op-12B: Biological Critical Medical Material Order

| Drugs | Size | Quantity | Use |
|---|---|---|---|
| Doxycycline 100mg tab | 500 tablets | 3 cases (24/case) | PEP, treatment |
| Ciprofloxacin HCL 500mg tab | 100 tablets | 40 Bottles | PEP, treatment |
| | | | |

**Notes**

Quantities of antibiotics were calculated based on U.S. Department of Health Metropolitan Medical Response System (MMRS) pharmaceutical recommendations. Guidelines suggest antibiotics for treatment/prophylaxis for 10,000 persons for every 400,000 in population. Treatment/prophylaxis includes 4 doses per person to cover the first 48 hours.

## Att-Op-12C: Chemical Antidotes Hospital Distribution Plan
(For Future Consideration)

Chemical Weapon Preparedness requires a different stockpile approach. Antidotes need to be immediately available to victims of a chemical exposure. Therefore, storing a set amount of antidote on emergency medical response vehicles, emergency departments and urgent cares is a prudent approach to planning. The grids contained on these pages are examples of chemical antidote site distribution and stockpile management documents.

| Medication | Distribution Site A | Distribution Site B | Distribution Site C | Distribution Site D | Total |
|---|---|---|---|---|---|
| Mark-1 Autoinjectors | X | X | X | X | XXX injectors |
| Diazepam 10mg Autoinjector | X | X | X | X | XXX injectors |
| Diazepam 5mg/ml 2ml SDV | XXX vials | XXX vials | XXX vials | XXX vials | XXX vials |
| Atropine 40mg/ml 20ml MDV | XXX vials | XXX vials | XXX vials | XXX vials | XXX vials |
| Pralidoxime HCL 1gm vial | XXX vials | XXX vials | XXX vials | XXX vials | XXX vials |

### Mark-1 Auto-Injectors Distribution Plan

| | Non-Transport | Transport | HAZMAT | Hospitals | Total |
|---|---|---|---|---|---|
| Quantity | XXX | XXX | XXX | XXX | XXX |
| Patients | patients at scene | patients at scene | patients at scene | patients in ED | - |
| Storage | in vehicle in insulated case | in vehicle in insulated case | in vehicle in insulated case | in pharmacy | - |
| Responsible For reports | EMS Officer | EMS Officer | EMS Officer | pharmacy director | - |
| Comments | | | | - | - |

**Non-Transport** means emergency vehicles not used for transport of patients such as Fire Command or Medical Director Vehicle.

**Att-Op-12C: Chemical Antidotes Hospital Distribution Plan**
(For Future Consideration)

**Transport** means emergency vehicles used for the transport and care of ill and injured.

**Hazmat** means contained within a Hazmat Response Vehicle.

**Hospitals** mean local hospitals providing emergency patient care. Urgent Care Centers or clinic sites could be included in this category.

**Att-Op-12D: Treatment Protocols**
(Draft Document does not contain all treatment protocols at this time.)

NEWS
The Food and Drug Administration
An Agency of the U.S. Department of Health and Human Services

October 18, 2001 Print Media: 301-827-6242
Broadcast Media: 301-827-3434
Consumer Inquiries: 888-INFO-FDA

The Food and Drug Administration today issued the following Public Health Advisory:

FDA PUBLIC HEALTH ADVISORY:
UPDATE ON USE OF DOXYCYCLINE FOR ANTHRAX EXPOSURE
Secretary of Health and Human Services Tommy G. Thompson announced on October 17 in testimony before the Committee on Governmental Affairs and Subcommittee on International Security, Proliferation and Federal Services of the United States Senate, that the Food and Drug Administration is approving new labeling for the use of several antibiotics to treat anthrax.

The following is being issued to provide healthcare providers with clarification on dosing regimens about doxycycline. In addition, FDA is developing more information about the use of this and other antibiotics to treat anthrax and will provide this information soon.

Doxycycline is approved for the treatment of anthrax in all its forms. The FDA is providing additional information concerning the dosing regimen for the treatment of anthrax, including cutaneous and inhalation anthrax (post-exposure). The currently recommended dosage regimen of doxycycline for severe disease is 100 mg every 12 hours for adults and 1mg per pound (2.2mg per kilogram) every 12 hours for children less than 100 pounds. These dosage regimens are appropriate for use in patients who have been exposed to anthrax (Bacillus anthracis) regardless of the route of exposure.

FDA and other health authorities strongly discourage individuals from taking any antibiotic for prevention of anthrax without the specific advice of a physician and a clear indication that exposure to the organism may have occurred.

**Att-Op-12D: Treatment Protocols**
(Draft Document does not contain all treatment protocols at this time.)

# Mixing and Dosing Chart for Doxycycline Mixture

### Mixing and Dissolving Doxycycline Tablets for Pediatric Use

Doxycycline can be dissolved in water, but water does not mask the bitterness. FDA tried mixing doxycycline with the following foods and drinks:

- lowfat white milk
- lowfat chocolate milk
- regular (whole) chocolate milk
- chocolate pudding
- grape jelly
- strawberry jelly
- yogurt with cherry flavor
- apple juice mixed with table sugar

The following foods and drinks mixed with doxycycline generally have an acceptable taste:

- lowfat white milk
- lowfat chocolate milk
- regular (whole) chocolate milk
- chocolate pudding
- apple juice mixed with table sugar

The following foods mixed with doxycycline do not hide its bitterness:

- jellies
- yogurt

Here are some points to keep in mind:

- Drinks work better than soft foods like pudding or jelly to dissolve the doxcycline tablet.
- Adding sugar to apple juice will help the mixture taste better.
- Extra sugar is not needed with sweet foods like chocolate milk and pudding.
- Chocolate milk and chocolate pudding hide the taste of doxycycline better than juice.

**Att-Op-12D: Treatment Protocols**
(Draft Document does not contain all treatment protocols at this time.)

## How to Mix 100 milligram (mg) Doxycycline with a food or drink

**Note:** To find out how much of this mixture to give a child, use the Dosing Chart below. For Geriatric indications see adult protocols.

The following instructions should be followed using measuring spoons that measure one (1) teaspoon and one half (½) teaspoon, if they are available. If measuring spoons are not available, please use the same metal teaspoon to grind the tablet, measure the food or drink, and give the medicine. For example, if you don't have a measuring spoon to give the child one and a half (1 ½) teaspoons of the medicine mixture, use the metal teaspoon to estimate as best you can. Because the amount of fluid is so small in a half teaspoon, it is better to give a little extra of the half teaspoon than not enough.

**You will need:**

- One (1) 100-mg doxycycline tablet
- A metal teaspoon
- Measuring spoons [one (1) teaspoon; and one half (½) teaspoon]
- 1 or 2 Small bowls
- One of these foods or drinks:
  - lowfat milk
  - lowfat chocolate milk
  - regular (whole) chocolate milk
  - chocolate pudding
  - apple juice mixed with table sugar*****

***If you use apple juice mixed with table sugar:**

- Use a measuring spoon to put four (4) level ***teaspoons*** of sugar and four (4) ***teaspoons*** of apple juice in a second small bowl.
- Stir the mixture until all the sugar is dissolved -- it may take several minutes.
- Using the measuring spoon, add four (4) ***teaspoons*** of the juice and sugar mixture into the first bowl with the doxycycline powder from one (1) 100-mg tablet. Mix them together until the doxycycline powder dissolves.

## Att-Op-12E: Checklists for Establishing a Regional Stockpile

| **To Establish a Regional Stockpile** | Status | Date completed |
|---|---|---|
| Determine membership of Regional Stockpile Oversight Committee | | |
| Designate stockpile sites in the region based on plan site selection criteria | | |
| Determine quantities of prophylaxis and treatment medications for purchase based on the regional population as provided in the plan. (See Appendix xxx for regional population) | | |
| Designate one or more stockpile sites as is appropriate for the region | | |
| Stockpile Oversight Committee shall develop Memorandum of Understanding (MOU) with the stockpile site/s regarding the key elements of the inventory maintenance, control, security, and distribution. | | |
| Stockpile Oversight Committee will also develop MOU with transportation companies or other agent who will transport the Interim Stockpile drugs to a requesting site during a WMD incident upon receipt of a valid request. | | |
| Stockpile Oversight Committee will meet at least on a yearly basis to carry out the responsibilities outlined in the plan. | | |
| Issues of stockpile rotation and replacement of outdates will be addressed by the committee | | |
| Regional protocols have been developed for use of the stockpile drugs based on established statewide treatment and prophylaxis protocols | | |
| Identify essential personnel to be treated in the event of a WMD situation to include those actually exposed, first responder and healthcare personnel, key government leaders, and family members of the above. | | |

**Ck-Ad-1A: Hospital Preparedness**

| # | Checklist: Hospital Preparedness | Yes | No | If No, Why or Action Plan | By Whom | By When |
|---|---|---|---|---|---|---|
| 1 | The hospital has a Hospital Bioterrorism Preparedness Coordinator (hereinafter, Coordinator), whose function is to be the contact person with the Regional Hospital Bioterrorism Preparedness Committee. | | | | | |
| 2 | The Coordinator understands that his/her function is to receive information from the Regional Hospital Bioterrorism Preparedness Committee (hereinafter, Committee) and share this information with appropriate staff at the hospital. | | | | | |
| 3 | The Coordinator has received an in-service regarding the HRSA Hospital Bioterrorism Preparedness Program (hereinafter, Program). | | | | | |
| 4 | The Coordinator has provided an in-service regarding the Program to senior management. | | | | | |
| 5 | The Coordinator has provided an in-service regarding the Program to the hospital's Emergency Management Committee. | | | | | |
| 6 | The Coordinator has provided an in-service regarding the Program to appropriate hospital staff. | | | | | |
| 7 | The Coordinator has provided an in-service regarding the Program to the Medical Staff. | | | | | |
| 8 | The Coordinator has provided an in-service regarding the Program to the hospital Board of Directors. | | | | | |
| 9 | The Coordinator has contact information for Committee. | | | | | |
| 10 | The Coordinator has contact information for the Regional Project Coordinator. | | | | | |

**Ck-Ad-1A: Hospital Preparedness**

| # | Checklist: Hospital Preparedness | Yes | No | If No, Why or Action Plan | By Whom | By When |
|---|---|---|---|---|---|---|
| 11 | The Coordinator has contact information for the Topic Experts. | | | | | |
| 12 | The Coordinator is registered on the Wisconsin Health Alert Network (HAN). | | | | | |
| 13 | The Coordinator has received an in-service on how to access information regarding the Program on the HAN. | | | | | |
| 14 | The Coordinator and the hospital's Emergency Management Committee of the hospital have a plan to implement the State Plan Template, using the checklists by December 31, 2003. | | | | | |
| 15 | The Coordinator has distributed the latest version of the State Plan to the Emergency Management Committee. | | | | | |

**Ck-Ad-1B: Purpose and Objectives**

| # | Checklist: Purpose and Objectives | Yes | No | If No, Why or Action Plan | By Whom | By When |
|---|---|---|---|---|---|---|
| 1 | The hospital has an Emergency Management Plan (JCAHO EC.1.4) | | | | | |
| 2 | The hospital has an Emergency Management Committee | | | | | |
| 3 | The hospital has an Emergency Management Committee, which meets at least quarterly | | | | | |
| 4 | The Emergency Management Committee has representatives from hospital administration… | | | | | |
| 5 | …nursing administration | | | | | |
| 6 | …infectious disease | | | | | |
| 7 | …pediatrics | | | | | |
| 8 | …intensive care | | | | | |
| 9 | …internal medicine | | | | | |
| 10 | …pharmacy | | | | | |
| 11 | …public relations | | | | | |
| 12 | …plant operations | | | | | |
| 13 | …emergency department | | | | | |



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Date: 8-27-2004

**Ck-Ad-1B: Purpose and Objectives**

| # | Checklist: Purpose and Objectives | Yes | No | If No, Why or Action Plan | By Whom | By When |
|---|---|---|---|---|---|---|
| 14 | …information systems | | | | | |
| 15 | …mental health | | | | | |
| 16 | …materials management | | | | | |
| 17 | …laundry | | | | | |
| 18 | …waste management | | | | | |
| 19 | …security | | | | | |
| 20 | …human resources | | | | | |

**Ck-Ad-1C: Membership**

| # | Checklist: Membership | Yes | No | If No, Why or Action Plan | By Whom | By When |
|---|---|---|---|---|---|---|
| 1 | The hospital has an Emergency Management Plan, which has been developed in collaboration with other emergency responders… | | | | | |
| 2 | …the County Emergency Management Office | | | | | |
| 3 | … the local health department | | | | | |
| 4 | … EMS | | | | | |
| 5 | …law enforcement | | | | | |
| 6 | …fire department | | | | | |
| 7 | …HazMat | | | | | |
| 8 | The hospital has chosen a "Primary" Regional Hospital Bioterrorism Preparedness Team | | | | | |
| 9 | The hospital has chosen an "Affiliate" Regional Hospital Bioterrorism Preparedness Team | | | | | |
| 10 | The hospital has patient referral relationships or other working relationships with border state healthcare providers and emergency responders. | | | | | |
| 11 | The hospital is involved in the emergency preparedness efforts of its border state partners. | | | | | |
| 12 | The hospital has a listing, including contact information, for all primary and affiliate hospital members in its region. | | | | | |



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**Ck-Ad-1C: Membership**

| # | Checklist: Membership | Yes | No | If No, Why or Action Plan | By Whom | By When |
|---|---|---|---|---|---|---|
| 13 | The hospital has a listing, including contact information, for all primary and affiliate local health department members in its region. | | | | | |
| 14 | The hospital has a listing, including contact information, for all primary and affiliate county Emergency Management directors in its region. | | | | | |
| 15 | The hospital has a listing, including contact information, for all primary and affiliate EMS members in its region. | | | | | |
| 16 | The hospital has a listing, including contact information, for all other primary and affiliate emergency response members in its region. | | | | | |

**Ck-Ad-1D: Scope of Plan**

| # | Checklist: Scope of Plan | Yes | No | If No, Why or Action Plan | By Whom | By When |
|---|---|---|---|---|---|---|
| 1 | The hospital's Emergency Management Plan has been adapted to deal with a qualified disaster – an incident that overwhelms the resources of the hospital. | | | | | |
| 2 | The hospital's Emergency Management Plan has a protocol in place to activate the State Hospital Plan. | | | | | |
| 3 | The hospital Emergency Management Plan address "all hazards" or BOIDOOPHTE. | | | | | |
| 4 | The Emergency Management Plan addresses the processes that need to be in place for a sustained disaster. | | | | | |
| 5 | Hospital staff have "Role Cards" or Job Descriptions that describe their responsibilities when the State Hospital Plan is activated. | | | | | |

**Ck-Ad-2: Post Incident Evaluation**

| # | Checklist: Post Incident Evaluation | Yes | No | If No, Why or Action Plan | By Whom | By When |
|---|---|---|---|---|---|---|
| 1 | The hospital has a protocol in place that, if it has been involved in the activation of the State Hospital Plan, the hospital will review the Post Incident Evaluation and adapt its plan as necessary, based on the Post Incident Evaluation. | | | | | |

**Ck-Ad-3: Plan Approval**

| # | Checklist: Plan Approval | Yes | No | If No, Why or Action Plan | By Whom | By When |
|---|---|---|---|---|---|---|
| 3A.1 | The hospital has a protocol in place to review its Emergency Management Plan at least every two years. | | | | | |
| 3A.2 | The hospital has a protocol in place to review its Emergency Management Plan at least every two years in light of any changes made to the State Hospital Plan. | | | | | |
| 3A.3 | The hospital Emergency Management Committee meets at least quarterly so that it can adapt its plan to recommendations made by the Regional Steering Committee from time to time. | | | | | |
| 3A.4 | The hospital has the State Hospital Plan as an attachment to its existing Emergency Management Plan. | | | | | |

**Ck-Op-1: Surveillance**

| # | Checklist: Surveillance | Yes | No | If No, Why or Action Plan | By Whom | By When |
|---|---|---|---|---|---|---|
| 1 | The hospital has a protocol for clinicians to report to the local health department any Category I, II or III communicable diseases. | | | | | |
| 2 | The hospital has readily available for its clinicians the FORM DPH 4151, on which to report thee Category I, II and III communicable diseases. | | | | | |
| 3 | The hospital has a protocol to implement Enhanced Surveillance as directed by the local health department or the Wisconsin Division of Public Health. | | | | | |
| 4 | The hospital has a protocol for the surveillance and reporting of the number of sick employees to the local health department. | | | | | |
| 5 | This protocol includes an office designated for the reporting of sick employees. | | | | | |
| 6 | This protocol includes a threshold number that triggers reporting the number of sick employees by the various departments in the hospital (if there is no central reporting). | | | | | |
| 7 | This protocol includes a threshold number that triggers reporting the number of sick employees to the local health department. | | | | | |
| 8 | The hospital has a protocol for the surveillance and reporting of unusual trends and spikes in diseases to the local health department. | | | | | |
| 9 | This protocol includes an office designated for the reporting of unusual trends and spikes in diseases. | | | | | |

**Ck-Op-1: Surveillance**

| # | Checklist: Surveillance | Yes | No | If No, Why or Action Plan | By Whom | By When |
|---|---|---|---|---|---|---|
| 10 | This protocol includes a threshold number that triggers reporting the unusual trends and spikes in diseases by the various departments in the hospital (if there is no central reporting). | | | | | |
| 11 | This protocol includes a threshold number that triggers reporting the unusual trends and spikes in diseases to the local health department. | | | | | |
| 12 | The hospital has policies that allow the disclosure of Public Health Information according to HIPAA standards. | | | | | |

**Ck-Op-3: Notification of an Incident**

| # | Checklist: Notification of an Incident | Yes | No | If No, Why or Action Plan | By Whom | By When |
|---|---|---|---|---|---|---|
| 1 | The hospital's Emergency Management Committee has adapted its plan so as to be able to manage a "Lights and Sirens" incident when activated under the State Hospital Plan.* | | | | | |
| 2 | The Emergency Management Committee has adapted its plan so as to be able to manage a "Biological" incident when activated under the State Hospital Plan.*. | | | | | |
| 3 | The hospital has a protocol in place to notify the 911 Center if the hospital is incapacitated due to some internal disaster. | | | | | |
| 4 | The hospital has a protocol in place to notify the 911 Center if the hospital can no longer treat further patients. | | | | | |
| 5 | The hospital's Emergency Management Plan has protocols that will be activated when presented with a suspect case of a CDC Category A, B and C disease or outbreaks of other infectious diseases. | | | | | |
| 6 | The hospital has protocols for the immediate notification of the local health department for all diseases listed in Section Twenty-One: Surveillance or DPH Form 4151, "Acute and Communicable Disease Case Report". | | | | | |
| 7 | The hospital has the protocols in place that will be activated once it is notified by the State or local health department that there is a suspect case of a CDC Category A, B and C disease or outbreaks of other infectious diseases. | | | | | |

* Complete adaptation of the hospital plan to the State Plan for this type of incident is contingent upon completing all the checklists for Part A, B and C of the State Plan.

## Ck-Op-4: Infecting Control Measures

| # | Checklist: Infection Control Measures | Yes | No | If No, Why or Action Plan | By Whom | By When |
|---|---|---|---|---|---|---|
| 1 | The hospital has a plan that can be implemented in response to an outbreak of smallpox. | | | | | |
| 2 | The hospital has a plan that can be implemented in response to an outbreak of SARS. | | | | | |
| 3 | The hospital has a plan that can be implemented in response to an influenza pandemic. | | | | | |
| 4 | The hospital has held at least a tabletop exercise to test its smallpox response plan. | | | | | |
| 5 | The hospital has held at least a tabletop exercise to test its SARS response plan. | | | | | |
| 6 | The hospital has held at least a tabletop exercise to test its influenza pandemic response plan. | | | | | |
| 7 | The hospital has protocols for registration staff in the Emergency Department to identify patients who may have contagious diseases. | | | | | |
| 8 | The hospital has protocols for registration staff in the Emergency Department to manage patients who may have contagious diseases. | | | | | |
| 9 | The hospital has in-serviced its EMS squads to notify the ER if they are transferring to the hospital a patient who may have a contagious disease. | | | | | |
| 10 | The hospital has available for consultation a dermatologist. | | | | | |
| 11 | The hospital has available for consultation an infectious disease specialist. | | | | | |
| 12 | The hospital has the 24/7 contact information for infectious disease consultants at the Wisconsin Division of Public Health. | | | | | |



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Date: 8-27-2004

## Ck-Op-4: Infection Control Measures

| # | Checklist: Infection Control Measures | Yes | No | If No, Why or Action Plan | By Whom | By When |
|---|---|---|---|---|---|---|
| 1 | The hospital has a plan that can be implemented in response to an outbreak of smallpox. | | | | | |
| 2 | The hospital has a plan that can be implemented in response to an outbreak of SARS. | | | | | |
| 3 | The hospital has a plan that can be implemented in response to an influenza pandemic. | | | | | |
| 4 | The hospital has held at least a tabletop exercise to test its smallpox response plan. | | | | | |
| 5 | The hospital has held at least a tabletop exercise to test its SARS response plan. | | | | | |
| 6 | The hospital has held at least a tabletop exercise to test its influenza pandemic response plan. | | | | | |
| 7 | The hospital has protocols for registration staff in the Emergency Department to identify patients who may have contagious diseases. | | | | | |
| 8 | The hospital has protocols for registration staff in the Emergency Department to manage patients who may have contagious diseases. | | | | | |
| 9 | The hospital has in-serviced its EMS squads to notify the ER if they are transferring to the hospital a patient who may have a contagious disease. | | | | | |
| 10 | The hospital has available for consultation a dermatologist. | | | | | |
| 11 | The hospital has available for consultation an infectious disease specialist. | | | | | |
| 12 | The hospital has the 24/7 contact information for infectious disease consultants at the Wisconsin Division of Public Health. | | | | | |

**Ck-Op-4: Infection Control Measures**

| # | Checklist: Infection Control Measures | Yes | No | If No, Why or Action Plan | By Whom | By When |
|---|---|---|---|---|---|---|
| 13 | The hospital has a negative pressure airborne isolation room (NPAir) in the Emergency Department. | | | | | |
| 14 | The hospital has protocols for the identification of a pre-identified room where a patient with a potential contagious disease may be segregated to minimize exposure to other patients and staff. | | | | | |
| 15 | The hospital has available a portable HEPA filtered unit that can be deployed to isolate the patient, who may have a contagious disease. | | | | | |
| 16 | Facilities staff have knowledge of the air flow characteristics of all rooms that may be used to treat a patient who may have a contagious disease so that HVAC strategies can be implemented to minimize transmission of airborne diseases. | | | | | |
| 17 | Facilities staff have calculated of the air exchange rates of all rooms that may be used to treat a patient who may have a contagious disease. (See Appendix XXXX) | | | | | |
| 18 | The hospital has pre-identified the preferred routes for the transport of contagious patients who may require testing or procedures. | | | | | |
| 19 | Clinicians and other staff have knowledge of how to quickly access the infection control and isolation protocols for patients with airborne diseases. | | | | | |
| 20 | The Emergency Department has available a digital camera so that pictures of lesions, pustules, and other cutaneous manifestations can be photographed and transmitted to consultants. | | | | | |
| 21 | There are staff trained in how to transmit digital images to consultants. | | | | | |

**Ck-Op-4: Infection Control Measures**

| # | Checklist: Infection Control Measures | Yes | No | If No, Why or Action Plan | By Whom | By When |
|---|---|---|---|---|---|---|
| 22 | The hospital has a trained Response Team, ready to be deployed in case of a contagious disease outbreak. | | | | | |
| 23 | Laboratorians are trained in the handling and transporting of contagious specimens. | | | | | |
| 24 | The hospital has protocols for the management of patients in NPAir. | | | | | |
| 25 | These protocols include, but are not limited to, protocols to minimize the number of patients, who enter the room of the contagious patient… | | | | | |
| 26 | …plans to educate family members and other visitors on the meaning of contact, airborne and standard precautions. | | | | | |
| 27 | …plans to provide fit-testing of N95 respirators for law enforcement | | | | | |
| 28 | …plans to provide fit-testing of N95 respirators for public health personnel | | | | | |
| 29 | …a logbook to track information for all persons who enter the room (See Appendix XXXX) | | | | | |
| 30 | …protocols for the use of disposable items | | | | | |
| 31 | …protocols for the disposal of waste | | | | | |
| 32 | …protocols for the laundering of linens | | | | | |
| 33 | …protocols for the management of patients when they are transported to different areas of the hospital | | | | | |
| 34 | …protocols for the notification of staff who may be exposed to the contagious patient during a test a or procedure | | | | | |
| 35 | ...protocols for the management of “close contacts” | | | | | |
| 36 | ...protocols for the detention of “close contacts” | | | | | |

**Ck-Op-4: Infection Control Measures**

| # | Checklist: Infection Control Measures | Yes | No | If No, Why or Action Plan | By Whom | By When |
|---|---|---|---|---|---|---|
| 37 | …protocols for assisting the local health department in the management "close contacts" | | | | | |
| 38 | …protocols for the cleaning of areas occupied by the contagious patient | | | | | |
| 39 | …protocols for decision-making regarding the quarantine of the hospital or of particular areas | | | | | |
| 40 | …protocols for the temporary termination of services by the hospital | | | | | |

**Ck-Op-5: Plan Activation**

| # | Checklist: Activation of the Plan* | Yes | No | If No, Why or Action Plan | By Whom | By When |
|---|---|---|---|---|---|---|
| 1 | The hospital has provided its staff with an in-service regarding the Incident Command System that is used by emergency responders. | | | | | |
| 2 | The hospital has provided its staff with an in-service regarding the role of the county or state Emergency Operations Center (EOC). | | | | | |
| 3 | The hospital has protocols to establish its own Incident Command System as part of its emergency response plan. | | | | | |
| 4 | The hospital has adopted the Hospital Emergency Incident Command System (HEICS) as the basis for its Incident Command System. | | | | | |
| 5 | The hospital has a dedicated phone line(s) and number(s) for its Incident Command Center. | | | | | |
| 6 | The hospital Incident Command Center has available the "Resource Listing"** from Part C of the State Plan, which lists the contact information for all emergency responders in the region. | | | | | |
| 7 | The hospital has a process in place to keep this "Resource Listing" up-dated. | | | | | |
| 8 | The hospital has a process in place for the hospital ICS to up-date staff during the emergency event regarding information necessary to manage the event. | | | | | |
| 9 | Upon activation of the State Hospital Plan, the hospital is prepared to share the "Hospital Capacity Report"*** with the EOC. | | | | | |

**Ck-Op-5: Plan Activation**

| # | Checklist: Activation of the Plan* | Yes | No | If No, Why or Action Plan | By Whom | By When |
|---|---|---|---|---|---|---|
| 10 | The hospital has identified the person (by function) who will serve as the hospital representative at the EOC, once it is activated. | | | | | |

* This checklist is not intended to address every element of the hospital's existing emergency response plan, which is mandated by JCAHO. This checklist addresses only those elements necessary and essential to adapt the hospital's existing emergency response plan to the State of Wisconsin Hospital Bioterrorism Preparedness Plan.

** Much of the information in the "Resource Listing will be provided to the hospital by the Regional Steering Committee.

*** The "Hospital Capacity Report" is the manual reporting form that is standardized across the State of Wisconsin for the reporting to the EOC of key capacity indicators.

## Ck-Op-6A: Hospital Receiving, Triage and Transportation

| # | Checklist: Hospital Receiving, Triage and Transportation | Yes | No | If No, Why or Action Plan | By Whom | By When |
|---|---|---|---|---|---|---|
| 1 | The hospital has reviewed its existing Emergency Management Plan to ensure that it is in compliance with all JCAHO standards for the management of a disaster. | | | | | |
| 2 | The hospital has reviewed its existing Emergency Management Plan so that the hospital can provide treatment to victims in a Level I disaster. | | | | | |
| 3 | The hospital has reviewed its patient transfer policies so as to implement them in a Level I disaster. | | | | | |

**Ck-Op-6B: Field Medical Command**

| # | Checklist: Field Medical Command | Yes | No | If No, Why or Action Plan | By Whom | By When |
|---|---|---|---|---|---|---|
| 1 | The hospital staff, especially staff in the Emergency Department, has received an in-service on how Medical Command works in the field as outlined in Section Six. | | | | | |
| 2 | The hospital has designated a person (by function) to serve as the hospital EOC representative, who will coordinate with the Transportation Group Supervisor regarding the transport of patients to the appropriate hospital. | | | | | |
| 3 | The hospital has designated a person (by function) to serve as the hospital EOC representative, who will coordinate with the Triage Group Supervisor regarding the triage of patients to the appropriate hospital. | | | | | |
| 4 | The hospital has its contact information, listed in the "Resource Listing", (for the EOC and others to access) including Emergency Room telephone numbers… | | | | | |
| 5 | …cellular or power failure telephone numbers for the Emergency Department | | | | | |
| 6 | … Incident Command Center phone number(s) | | | | | |
| 7 | …cellular or power failure telephone numbers for the Incident Command Center | | | | | |
| 8 | …preferred method(s) to contact the Incident Commander (pager, phone switchboard, etc.) | | | | | |
| 9 | Also to be included in the "Resource Listing" are EMS radio frequencies used by the hospital. | | | | | |

**Ck-Op-6C: Patient Field Triage**

| # | Checklist: Patient Field Triage | Yes | No | If No, Why or Action Plan | By Whom | By When |
|---|---|---|---|---|---|---|
| 1 | The hospital has adapted its existing Emergency Management plan to the protocols as outlined in Section Seven. | | | | | |
| 2 | The hospital has provided staff with an in-service regarding the protocols outlined in Section Seven. | | | | | |
| 3 | Inter-Facility Transfer Agreements have been up-dated OR have been replaced with the Memorandum of Understanding for the diversion of patients, sharing of staff and equipment, and credentialing. | | | | | |
| 4 | The hospital has a protocol for recording and correlating the EMS Disaster Tag ID with the patient number assigned to the victim upon arrival at the hospital. | | | | | |

## Ck-Op-6D: Incident Termination

| # | Checklist: Incident Termination | Yes | No | If No, Why or Action Plan | By Whom | By When |
|---|---|---|---|---|---|---|
| 1 | The hospital has the protocols in place to notify staff internally that the incident is terminated pre-hospital. | | | | | |

**Ck-Op-7: Increasing Bed Capacity**

| # | Checklist: Increasing Inpatient Bed Capacity | Yes | No | If No, Why or Action Plan | By Whom | By When |
|---|---|---|---|---|---|---|
| 1 | The hospital has a protocol in place to notify attending physicians that they will need to activate the plan to increase inpatient bed capacity. | | | | | |
| 2 | The hospital has a plan to increase inpatient bed capacity. | | | | | |
| 3 | The plan includes protocols for the early discharge of patients. | | | | | |
| 4 | The plan includes protocols to transfer patients to other hospitals. | | | | | |
| 5 | The plan includes protocols to transfer patients to nursing homes. | | | | | |
| 6 | The hospital has plans for the interfaculty transfer of patients. | | | | | |
| 7 | The hospital has plans to transfer patients within the hospital to maximize inpatient bed capacity or to free negative pressure airborne isolation rooms. | | | | | |
| 8 | The hospital has plans for the cancellation of scheduled surgeries. | | | | | |
| 9 | The hospital has protocols to prioritize necessary admissions. | | | | | |
| 10 | The hospital has protocols for the cancellation of elective admissions and surgeries. | | | | | |
| 11 | The hospital has protocols to triage and divert patients from its Emergency Room to alternative treatment sites such as urgent care centers or primary care offices. | | | | | |
| 12 | The hospital has preidentified hospitals to which it will transfer or divert patients who need specialized care such as ICU. | | | | | |
| 13 | The hospital has protocols to convert private rooms into rooms that can house multiple patients. | | | | | |

**Ck-Op-7: Increasing Bed Capacity**

| # | Checklist: Increasing Inpatient Bed Capacity | Yes | No | If No, Why or Action Plan | By Whom | By When |
|---|---|---|---|---|---|---|
| 14 | The hospital has protocols to open closed patient care areas and convert them to patient care areas. | | | | | |
| 15 | The hospital has protocols to convert existing on-site space such as meeting rooms, waiting areas, etc. into patient care areas. | | | | | |
| 16 | The hospital has designated a person or function to complete the “Hospital Capacity and Patient Census Report.” | | | | | |
| 17 | The hospital has available in its Incident Command Center Part C: Resource Listing that will include to where the “Hospital Capacity and Patient Census Report” will need to be sent. | | | | | |
| 18 | Hospital staff has the training to utilize the "Hospital Capacity Report”. | | | | | |
| 19 | The hospital has a back-up communications system(s) in place to communicate the “Hospital Capacity Report”. | | | | | |
| 20 | The ICS has protocols for determining the adequacy of staffing to manage the incident. | | | | | |
| 21 | The hospital has protocols for the call-in of staff. | | | | | |
| 22 | The hospital has a human resource plan that documents how it will staff the extra capacity that will be established through the above protocols for increasing inpatient bed capacity. | | | | | |
| 23 | The hospital ICS has Part C: Resource Listing that lists whom to call in the City/County EOC to request additional staff. | | | | | |
| 24 | The hospital has available a listing of ICU resources for all hospitals in the region from the “Resource Listing” in Part C of the State Plan. | | | | | |

**Ck-Op-7: Increasing Bed Capacity**

| # | Checklist: Increasing Inpatient Bed Capacity | Yes | No | If No, Why or Action Plan | By Whom | By When |
|---|---|---|---|---|---|---|
| 25 | The hospital maintains a log of staff that has been vaccinated against smallpox. | | | | | |

**Ck-Op-9: Security**

| # | Checklist: Security | Yes | No | If No, Why or Action Plan | By Whom | By When |
|---|---|---|---|---|---|---|
| 1 | The hospital has a security plan, which includes, but is not limited to designated security staff… | | | | | |
| 2 | …additional security staff who can be deployed | | | | | |
| 3 | ...security staff have vests for identification purposes | | | | | |
| 4 | ...security staff have designated assignments | | | | | |
| 5 | …security staff have periodic training | | | | | |
| 6 | …security staff have job action sheets | | | | | |
| 7 | …security staff have protocols to provide security staffing in a sustained disaster | | | | | |
| 8 | The hospital has a “lockdown” protocol. | | | | | |
| 9 | The hospital has a protocol for the identification of physicians and staff who will enter the facility during a lockdown. | | | | | |
| 10 | The hospital has a protocol for the identification of others such as fire, law enforcement, public health, etc. who will enter the facility during a lockdown. | | | | | |
| 11 | The hospital has established a plan to set up a security perimeter and has the cooperation of law enforcement in the establishing and enforcement of this perimeter. | | | | | |
| 12 | There are designated ingress and egress routes into and out of the hospital. | | | | | |
| 13 | The hospital has a plan to establish a patient triage center at the security perimeter. | | | | | |
| 14 | The security plan includes signage that is ready to be posted. | | | | | |
| 15 | The hospital has a plan to call-in security staff. | | | | | |
| 16 | Traffic flow patterns have been established in cooperation with law enforcement. | | | | | |

**Ck-Op-9: Security**

| # | Checklist: Security | Yes | No | If No, Why or Action Plan | By Whom | By When |
|---|---|---|---|---|---|---|
| 17 | The hospital has public address systems to communicate with potential crowds outside the facility. | | | | | |
| 18 | Security knows where to direct media. | | | | | |
| 19 | Security has a log for all persons entering the facility through the security perimeter at which people log in time of entrance and time of departure. | | | | | |
| 20 | There is a protocol developed in collaboration with law enforcement on when and how to search persons or their belongings and who will be responsible for this function. | | | | | |
| 21 | There is a plan for communications with and among security personnel. | | | | | |

## Ck-Op-11: Disposal of Waste

| # | Checklist: Disposal of Waste | Yes | No | If No, Why or Action Plan | By Whom | By When |
|---|---|---|---|---|---|---|
| 1 | The hospital is presently in compliance with NR 526 – Medical Waste Management. | | | | | |
| 2 | The hospital is in compliance with local government regulations regarding the disposal of medical waste from their hospital. | | | | | |
| 3 | The hospital has a list of the supplies, needed for the disposal of biological waste, that are in normal inventory. | | | | | |
| 4 | The hospital has an estimate of how long this inventory will last and for how many patients. | | | | | |
| 5 | The hospital has signed the MOU with other hospitals in its region to allow for the sharing of supplies. | | | | | |
| 6 | The hospital has a protocol for requesting needed supplies from the EOC, if activated. | | | | | |
| 7 | The hospital has a protocol for requesting refrigerated storage for biological waste from the EOC, if activated. | | | | | |
| 8 | The hospital has a protocol for requesting refrigerated storage for biological waste from the City/County Emergency Management Office, if the EOC is not yet activated. | | | | | |
| 9 | The hospital has a protocol to maintain the security of biological waste that may be stored temporarily on-site at the hospital. | | | | | |
| 10 | The hospital staff, responsible for the handling of biological waste, has the necessary personal protective equipment. | | | | | |
| 11 | The hospital staff, responsible for the handling of biological waste, has been trained in how to use the personal protective equipment. | | | | | |

**Ck-Op-12: Interim Stockpile**

| # | Checklist: Interim Stockpile | Yes | No | If No, Why or Action Plan | By Whom | By When |
|---|---|---|---|---|---|---|
| 1 | The hospital has available for its clinicians the Formulary of the Interim Stockpile. | | | | | |
| 2 | The hospital has a protocol for requesting the Interim Stockpile. | | | | | |
| 3 | The hospital has the 24/7 contact information for the local health department. | | | | | |
| 4 | The hospital has a protocol for the receipt of the Interim Stockpile. | | | | | |
| 5 | The hospital has a protocol for recording what has been distributed from the Interim Stockpile. | | | | | |
| 6 | The hospital has available for its clinician the dispensing protocols as found in Appendix 18-D. | | | | | |

**Ck-Op-14: Risk Communication**

| # | Checklist: Risk Communications | Yes | No | If No, Why or Action Plan | By Whom | By When |
|---|---|---|---|---|---|---|
| 1 | The hospital Incident Command Center and the Public Information Officer (PIO) is familiar with the purpose and operations of the Joint Information Center (JIC), when it is activated. | | | | | |
| 2 | The hospital has protocols for managing media information through the JIC, when it is activated. | | | | | |
| 3 | The hospital has protocols for managing media information through the City/County EOC, when it is activated. | | | | | |
| 4 | The hospital is familiar with the information that will be made available to it through the Wisconsin Division of Public Health. | | | | | |
| 5 | The hospital staffs, especially those who work in the hospital Incident Command Center, are familiar with the role and purpose of the State Emergency Operations Center (see Appendix 19-A). | | | | | |
| 6 | The hospital staff, especially those who work in the hospital Incident Command Center, are familiar with the role and purpose of Joint Information Center (JIC) (See Appendix 19-A). | | | | | |
| 7 | The hospital has protocols that all media communications, in a disaster, are to be conducted through the JIC, if activated, or, otherwise, through the City/County EOC. | | | | | |
| 8 | The hospital has protocols that the condition of patients, in a disaster, may be released to the JIC, if activated, or, otherwise, to the City/County EOC. | | | | | |

**Ck-Op-14: Risk Communication**

| # | Checklist: Risk Communications | Yes | No | If No, Why or Action Plan | By Whom | By When |
|---|---|---|---|---|---|---|
| 9 | The hospital has noted in its emergency management plan what information will be provided by the JIC (see Sec. 19, A.2.d.) | | | | | |
| 10 | The hospital has noted in its emergency management plan what information will be provided to healthcare providers through the Wisconsin Division of Public Health (see Sec. 19. B.1.b.) | | | | | |
| 11 | The hospital has noted in its plan that Risk Communications will be made available through the Wisconsin Division of Public Health in the following languages: English, Spanish, Hmong. | | | | | |

## Ck-Op-15: Response Work Force

| # | Checklist: Responder Workforce | Yes | No | If No, Why or Action Plan | By Whom | By When |
|---|---|---|---|---|---|---|
| 1 | The hospital has Emergency Credentialing protocols in its Medical Staff By-Laws and Rules and Regulations. | | | | | |
| 2 | The hospital has persons available 24/7 to credential healthcare professionals, who may report directly to the hospital in a disaster. | | | | | |
| 3 | The hospital has a protocol in place to request healthcare professionals through the City/County EOC, if necessary. | | | | | |
| 4 | The hospital has available the "Licensed Responder Workforce Deployment Request" (See Appendix 23-C). | | | | | |
| 5 | The hospital has persons trained to complete the above Request Form. | | | | | |
| 6 | The hospital has a protocol to report to the City/County EOC the status of deployed responders on an hourly basis. | | | | | |
| 7 | The hospital has a protocol to prove the identity of responders, who are deployed to the hospital by the EOC. | | | | | |
| 8 | The hospital has available for responders to sign the "Deployment of Licensed Healthcare Professionals Agreement". (See Appendix-E) | | | | | |
| 9 | The hospital has a protocol to have physician responders self-identify their Residency Status and Level of Residency and their Critical Care capability. | | | | | |
| 10 | The hospital has a protocol to have other licensed healthcare responders self-identify their specialty and special training and competencies. | | | | | |

**Ck-Op-15: Response Work Force**

| # | Checklist: Responder Workforce | Yes | No | If No, Why or Action Plan | By Whom | By When |
|---|---|---|---|---|---|---|
| 11 | The hospital has a protocol in place to request non-licensed healthcare workers and volunteers through the City/County EOC. | | | | | |
| 12 | The hospital has available the "Non-Licensed Responder Workforce Deployment Request" (See Appendix 23-D). | | | | | |
| 13 | The hospital has persons trained to complete the above Request Form. | | | | | |
| 14 | The hospital has a protocol to have other licensed healthcare responders self-identify their specialty and special training and competencies. | | | | | |
| 15 | The hospital has a protocol to have non-licensed healthcare responders self-identify their special training and competencies. | | | | | |

## Ck-Op-16: Training and Education

| # | Checklist: Training and Education | Yes | No | If No, Why or Action Plan | By Whom | By When |
|---|---|---|---|---|---|---|
| 1 | The hospital has a list of the Core Curriculum for Hospital Bioterrorism Preparedness, which is published annually on September 1. | | | | | |
| 2 | The hospital has a process to provide feedback to the Regional Hospital Preparedness Team regarding its training and educational needs for Bioterrorism Preparedness. | | | | | |
| 3 | The hospital has a process for informing its physicians and staff regarding the availability of the Core Curriculum and how it can be accessed. | | | | | |
| 4 | The hospital has an identified person or function that can access reports on who at the hospital has completed various training/education programs. | | | | | |